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G. Tayloe Gwathmey

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Lorenzo L. Parks

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Curtis D. Benton, Jr.

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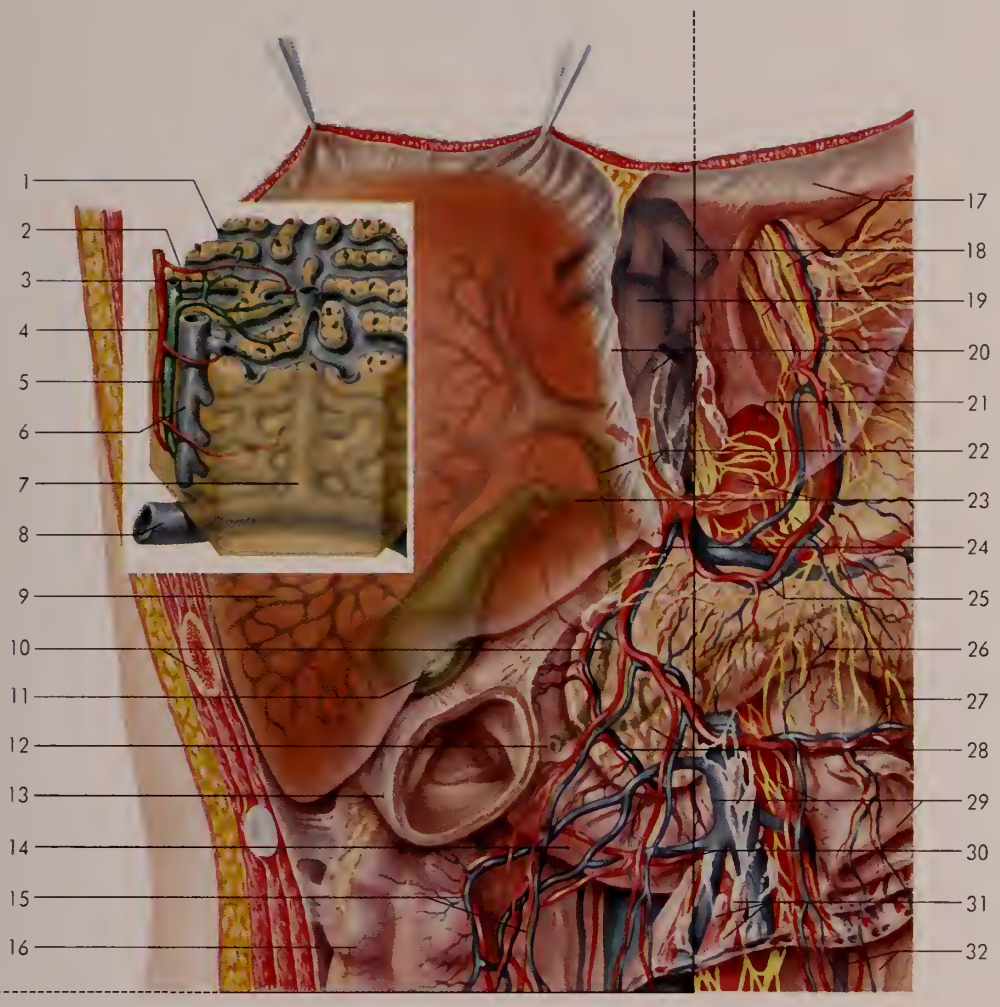
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13 Transverse colon
14 Duodenum
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16 Ascending colon
17 Coronary ligament and esophagus
18 Left hepatic vein and left vagus nerve
19 Inferior vena cava and right vagus nerve
20 Falciform ligament and branch of portal vein
21 Abdominal aorta and celiac plexus
22 Hepatic duct and hepatic artery
23 Cystic duct and celiac artery
24 Celiac ganglion and gastroduodenal artery and vein
25 Left gastric artery and coronary vein
26 Pancreatic duct
27 Right gastroepiploic artery and vein
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Recent basic research on the influence of fats and cholesterol on human health has done much to further progress in the fight against atherosclerosis. It will serve well in dispelling the mistaken fear that reasonable amounts of foods of animal origin predispose the individual to this vascular disease.[6] As a matter of fact, a dietary inadequate in essential nutrients but providing too many calories and too much fat from *any* source may well be an important factor underlying the deposition of fat and cholesterol in the arteries and liver.

Cumulative evidence indicates that lowered blood levels of cholesterol may be effected by restricting the total fat intake.[1] Except in instances of refractory hypercholesteremia, in which a daily fat intake as low as 10 Gm. may not reduce cholesterol levels to normal, diets containing 20 to 30 Gm. of fat, or even more, often produce low cholesterol blood levels. In the clinical application of this principle, various palatable, low fat diets which supply three servings of meat daily (containing 18 Gm. of fat) have recently been suggested for the dietary management of arteriosclerosis and for enlisting the cooperation of patients.[1] The meat servings were chosen from a large variety of cuts and kinds of meat (fat trimmed off, as lean as possible). Meat adds to the eating appeal of the fat-restricted diet and contributes important amounts of biologically complete protein, the B group of vitamins including B_{12}, and food iron—all of which are important for a good state of nutrition in the atherosclerotic patient.

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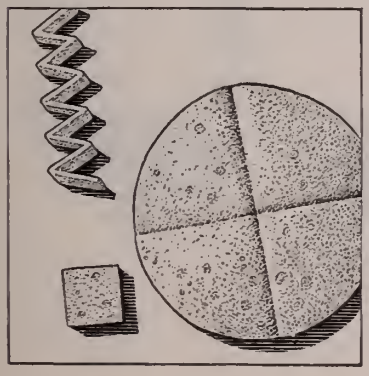
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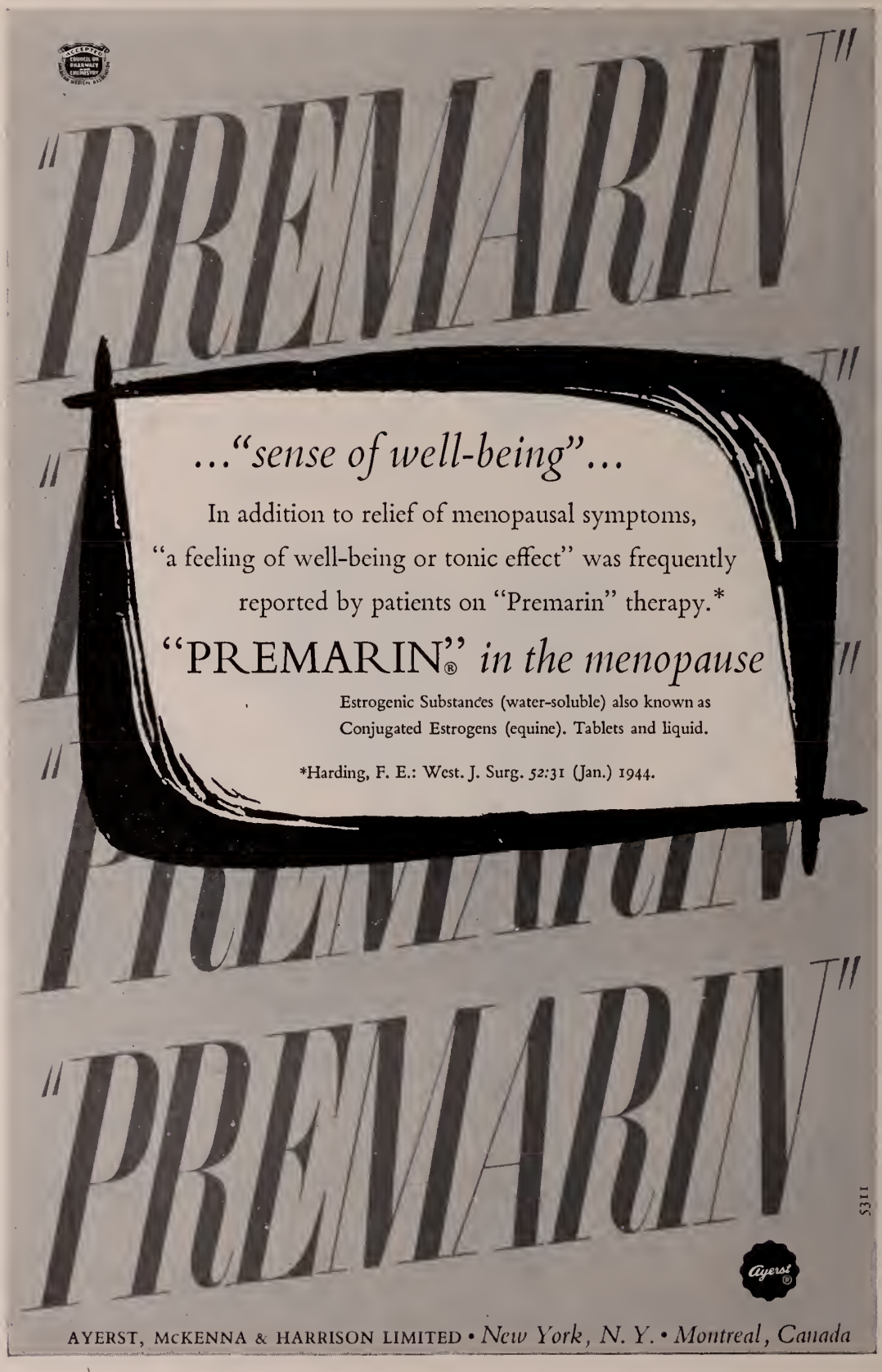
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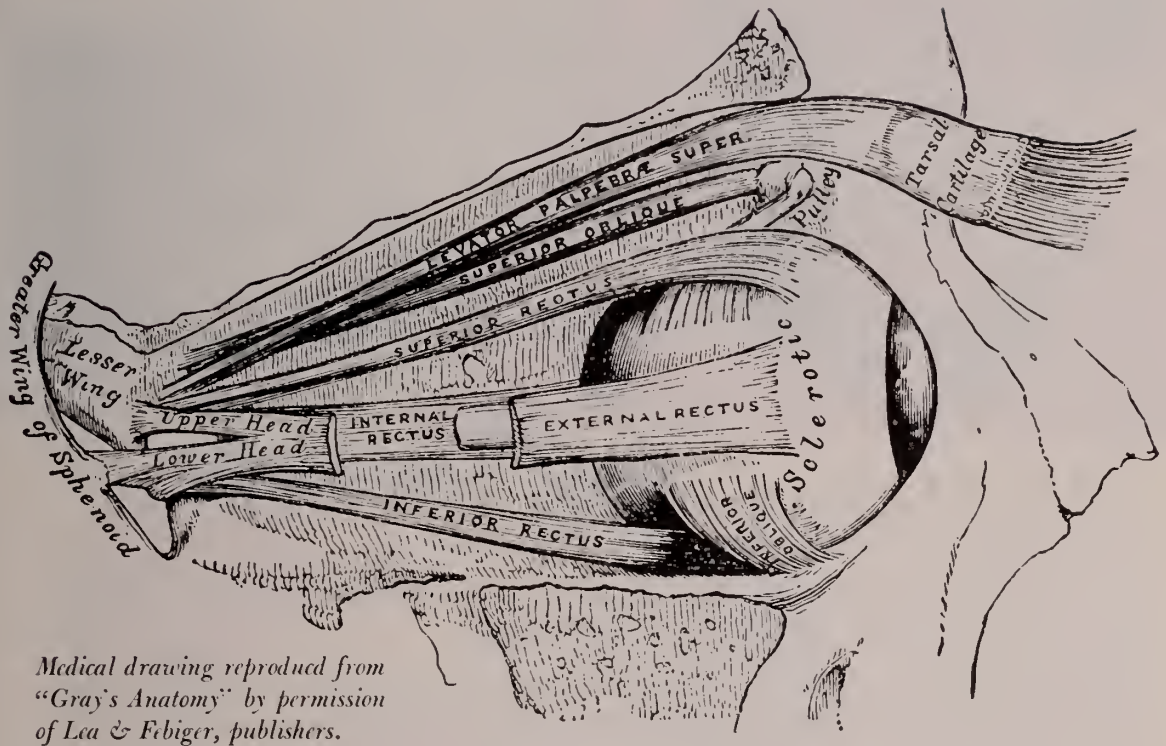
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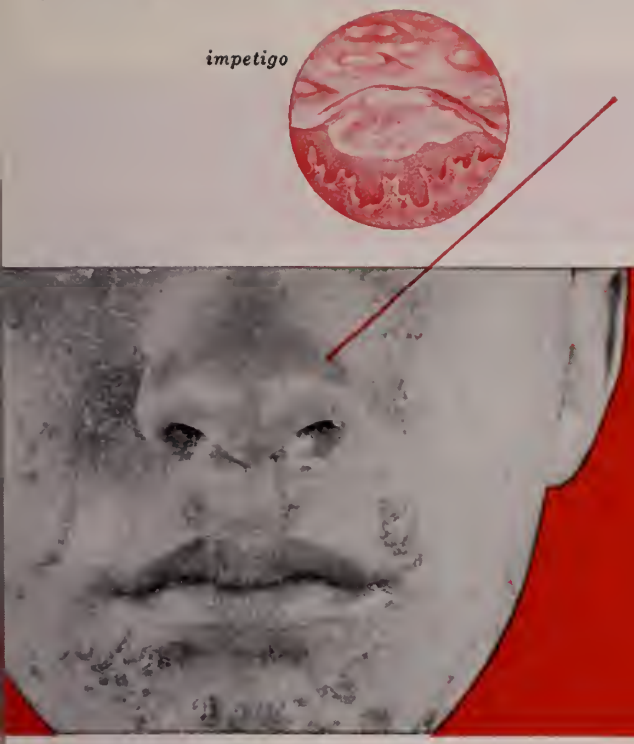
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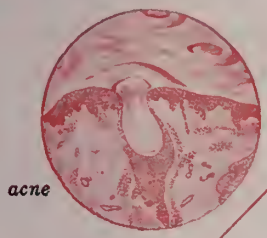
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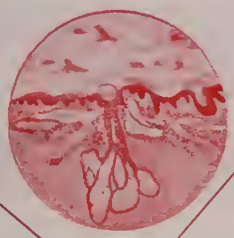
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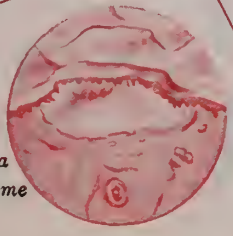


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The Ocular Neuroses

G. Tayloe Gwathmey, M.D.
ORLANDO

In June of 1930, Dr. George Derby read a paper on the subject of ocular neuroses before the Section on Ophthalmology of the American Medical Association. It was an informal presentation, but nevertheless this paper, with the illuminating discussions which followed by Wilmer, Lancaster, DeSchweinitz and others, constitutes, as far as I have been able to find, the nearest approach we ophthalmologists have to a classic on the subject. Many of us have read it, but it will repay anyone who reads it again.

The purpose of this paper is not to exhaust its subject, but to contribute as much as possible, in the time available, to the working tools of the practicing ophthalmologist.

To discuss the ocular neuroses without reference to the neurotic personality or, if you prefer, the neurotic character structure, would be inappropriate. Yet to cover the subject of the neurotic character structure in any thorough manner is manifestly beyond the scope of this presentation. Nevertheless. I think that a thumbnail sketch of what is at least a useful working hypothesis might be worth while.

A Working Hypothesis

As a working hypothesis it is useful to regard fear as a prime mover. The question of whether or not it is the prime mover we can unsafely leave to the philosophers. The operation of fear in the fox which flees before the hound is simple and clear. The fact that fear of going hungry is operating through channels to motivate the hound is less obvious. The fact that fear of being socially unacceptable is operating through devious channels to motivate the hunter who follows the hound is much less obvious.

The concept of fear as a prime mover can be a useful one. Fear is far older than the human race. It is even a little older and a little more elemental than sex. Sex makes creatures move at certain periods of their existence. Fear makes them move from the day they are born until the day they die. And if a creature cannot move in one direction, fear will drive it to move in another. And if it cannot move in that direction, fear will drive it to move in a third direction. And if it cannot move successfully in any direction, it will be frustrated. And if it is frustrated sufficiently, it will manifest the signs and symptoms of the neurotic character structure.

Not so old as fear and sex, but old indeed, is love. Much has been sung and much has been said on the subject of love. I submit with a great deal of humility the thesis that love is an alliance against fear.

Sex is an ancient and a powerful force. When the power of sex and the alliance of love are harmoniously working together, then fear is at a low ebb, frustration loses its support, and all goes well. The lack of the signs and symptoms of the neurotic character structure, while this happy state of affairs prevails, is manifest to every observant clinician.

Of all the fears, I doubt if any is so old, so universal, and so deep, as the fear of helplessness. Who among us has not dreamed that he was pursued and could not run, or that he was in a fight and could not move his arms? There are many forms of helplessness which are consciously dreaded. Paralysis is one example, and poverty is another. There is, however, a form of helplessness which is consciously dreaded by a few and unconsciously dreaded by a great many, and that form of helplessness is blindness. No doubt, there are

Read before the Florida Society of Ophthalmology and Otolaryngology, Thirteenth Annual Meeting, Hollywood, April 27, 1952.

cases in which the fear of blindness is due, as Freud said, to a sense of guilt over having used the eyes to see something forbidden. But I cannot see the need of postulating this elaborate mechanism in most cases. Fear of helplessness is fully comprehensible to creatures in whom sex is an uncomplicated affair. It takes no great amount of discernment on the part of the unconscious mind to perceive that blindness is helplessness.

The only reason a dog does not fear blindness as such is that the nature of blindness cannot, fortunately, be explained to him. But it can, unfortunately, be explained to a child aged 5 or even 4, and in my experience a history of having been impressed in early childhood with blindness, as a form of helplessness, can be obtained without much difficulty in over half of the cases in which patients manifest symptoms of ocular neuroses. Other writers have mentioned this finding in the history, but I think its frequency has been underestimated.

Duke-Elder's division of ocular neuroses, which he properly calls functional ocular disturbances, into two main groups is useful. He divides the affective reaction states from the hysterical states, and then mentions malingering as being of conscious but nevertheless psychic origin. With malingering this paper is not concerned.

Hysterical States

The hysterical states I will mention but briefly. True hysterical blindness, a fascinating but in my experience a rare condition, should be easily diagnosed by the ophthalmologist, and referred for treatment by a psychiatrist. Lesser degrees of amblyopia which are hysterical in origin are not so rare. A recent case is worth citing.

The patient, at the age of 80, was an extremely active and self-sufficient person whose vision was down to 20/200 from cataracts. The extent to which this poor vision interfered with his amazing and lucrative activities annoyed him excessively, and he submitted to operation. All went well, and I was delighted at a fine clear view of a perfect fundus that looked about 60 years of age. But although he insisted he could see beautifully, he could not read but 20/400 on the Snellen chart. The discrepancy between his euphoric reaction and a vision of 20/400 pointed, of course, straight to hysterical amblyopia. My view of the matter was that this painfully independent and belligerently self-sufficient old character was just so terribly afraid that he would not see after the operation that he actually supressed his acuity down to 20/400. I prescribed the correction by retinoscopy and gave him as much reassurance as my own assurance could muster, and the following week when he read 20/30 with that same correction, my relief can be imagined.

The hallmark of hysterical amblyopia is that the loss of function does not fit with any organic diagnosis, and there are discrepancies which are often clearly diagnostic of an hysterical basis. In the treatment of cases of this type, there is no substitute for judgment on the part of the ophthalmologist. If the whole character structure of the person is clearly of an hysterical nature, and the amblyopia is only one manifestation of an hysterical makeup, the patient should be in the hands of a psychiatrist. On the other hand, if some specific occurrence has frightened the patient into an hysterical amblyopia, I have found that careful reassurance and sympathetic handling will nurse the vision back to normal. On the subject of reassurance, more later.

The hysterical states are characterized by loss of function with less emphasis on symptoms, while the affective reaction states are characterized by distressing symptoms with little or, more usually, no loss of function.

Ocular Manifestations of Anxiety

Of the affective reaction states, far and away the most important is the anxiety state, and it is the only one with which this paper is to be concerned. And if I have anything worth saying, it is this: the full blown anxiety state is easy to recognize, but anxiety is a matter of degree, and to some degree anxiety, apprehension, fear, or whatever you wish to call it, lurks behind every pair of eyes that comes into your office. The need to recognize the degree of anxiety, and to ignore it if advisable, to probe it if necessary, to quench its thirst for reassurance while adding nothing to its stature, in short to deal with it to the patient's best interest, this need is the reason medicine is called a healing art instead of a healing science.

In considering the ocular manifestations of anxiety, it is of course fundamental to understand that conscious fear appears as conscious fear, whereas unconscious fear appears as symptoms. This is an obvious but important distinction. For example, a patient whose mother had glaucoma is apt to come to us consciously seeking reassurance that glaucoma is not present. This is anxiety, but is not neurosis. If, however, a patient's fears for the integrity of his vision are unconscious, he will come to us with symptoms. These symptoms

are the only form in which his anxiety is acceptable to his conscious mind.

It probably will be helpful to consider the late and extreme form of ocular neurosis, or anxiety state, at this point. We have all seen a few examples. The patient is apt to be a woman, and past 60 years of age. She is a typical neurotic, doing her best to make her world revolve around her distressing condition. She wears the darkest of dark glasses and a black veil as well. She shrinks from a window even though it is a cloudy day. Testing the reaction of her pupils is a formidable undertaking, and her tale of woe is of headaches, prostration and having to be read to for the last 20 years. Many and notable are the ophthalmologists whom she has consulted with only temporary relief. As for her glasses, their quantity exceeds their variety by a good deal.

It has been my experience that this type of patient is beyond any help except superficial help. She receives reassurance gratefully, but its effect is only temporary. And yet, the attempts I have made at this stage of the ocular anxiety state to tell the patients the truth have met with conspicuously poor results. The only advantage I have found in trying to tell these people the truth is that it sends them to another ophthalmologist more quickly than they would have got there otherwise. Consequently, I resort to sympathy and palliative treatment. And although a description of these patients has a humorous side, they are sick people, and sympathy for their condition is not hard to summon if you stop to consider how much they are being cheated of what is left to them of life. It is still easier to be sympathetic with them when you consider that earlier in their lives, more than one member of our fraternity had an opportunity to prevent this dismal state of affairs and failed to do so.

If we seek a more fruitful field for our efforts, we must turn to younger persons, the ones in the earlier stages of the ocular anxiety state. How are we to recognize them, and how are we to treat them?

To recognize them, one must weigh their symptoms against what findings there are to explain those symptoms. For instance, itching of the eyes is sometimes of purely nervous origin. It is more often of allergic origin. But the appearance of the conjunctiva will usually, though not infallibly, tell us which is the case. Burning of the eyes is a more ambiguous symptom. It may be blepharitis, avitaminosis, astigmatism or anxiety. If no other explanation can be found, anxiety should certainly be suspected. Headache is, of course, more ambiguous still, and although one of the foremost symptoms of anxiety, it is certainly in a great many cases independent of anxiety. The complaint of headache after using the eyes, however, in the absence of a considerable uncorrected refractive error or muscle imbalance, should at least arouse our suspicions. The complaint of pain in the eyes, in the absence of ocular or sinus pathology, is definitely indicative of anxiety.

But in my view and in my experience, the hallmark of anxiety is psychic photophobia, for the causes of somatic photophobia are few, and except for sinusitis and a few rarities are perfectly definite on slit lamp examination. When a patient with eyes that are absolutely normal on slit lamp examination complains that the light bothers him, it is my unequivocal opinion that that patient has enough ocular anxiety to require specific and careful and adroit reassurance. Sinusitis and the rare other exceptions to this rule are not difficult to rule out. It is important to make a distinction between a patient who volunteers the fact that the light bothers him and one in whom this symptom is elicited by questioning. It is, of course, only a difference in degree, but the degree of anxiety is what is important. The extent of the patient's predilection for tinted lenses is also useful in estimating the degree of anxiety.

Finally, there is another finding which is diagnostic of ocular anxiety. This is a history of frequent changes of lenses, with temporary relief from symptoms having been obtained from insignificant changes in prescription. This finding has the disadvantage of not being apparent early in the course of the ocular neurosis. It has this to be said for it, however; it clearly informs the examiner that the ocular neurosis is no longer in its infancy, and that he must give his best efforts then and there toward letting it go no further.

Principles of Reassurance

On the subject of treatment, each of us must answer for himself the question of whether or not the ocular neurosis is so clearly a manifestation of a thoroughly neurotic character structure that the patient would be better off in the hands of a psychiatrist. This question naturally depends upon the skill of the psychiatrists available to the patient. The great majority of patients that come to us with varying degrees of ocular anxiety are best handled by reassurance from the ophthalmologist.

The strategy, tactics, and technic of reassurance are a study in themselves, and beyond the scope of this paper. A few basic principles, however, should be mentioned.

The first principle is best quoted directly from Derby: "A diagnosis of neurosis is not hard to arrive at, but once it has been made, one should be prepared to spend some time on the patient, or, if not, to send the patient to some one else who will." I believe that in every case of ocular anxiety requiring specific reassurance the eyes should be carefully examined by means of the slit lamp. There are two reasons for this examination: first, it makes the examiner more than ever certain of his ground, and the patient senses this certainty; second, it adds to the patient's conviction that his eyes have been thoroughly examined. How far one should go with fields, blind spots, dark adaptation, fatigue of accommodation, and so on depends of course both on the nature of the patient and the personality of the examiner. But the principle is simple, namely, carry the examination far enough in each case so that when the patient is told there is nothing organically wrong with his eyes, he will believe it with implicit confidence. I believe that this principle holds good for all ages and is not controversial.

A second principle is that of combating the almost universal misconception that because of the delicacy of their mechanisms, the eyes can be easily and permanently damaged by use. In this connection, I wish not to deprecate, but to condemn, the practice of frightening patients, young or old, about their eyes. A great deal of harm is done by telling patients, and especially young and impressionable ones, that they will ruin their eyes if they do not wear glasses all the time. This monstrous falsehood has no place in medical practice, and in my opinion the fact that parents have an undisciplined child does not excuse the practitioner for resorting to it.

A third principle may be described as ritualistic suggestion. Bahn of New Orleans appears to have carried this to its ultimate extreme, and to have got, according to his account, conspicuously good results with it. He directs in detail practically every moment of the anxious patient's life. He tells him precisely when and how to sleep, when, what and how to eat, when and how to exercise, when and how to bathe, when and how to breathe, when and how little to smoke, when and how little to drink, and when and how much to work. The significant thing about his results, however, is that as soon as the patient desists from this incredible regimentation, the symptoms of ocular neurosis promptly recur. In commenting upon this degree of ritualistic suggestion, I think two points should be made: first, it raises at least the suspicion that the treatment is worse than the disease, and second, having myself admitted defeat in the treatment of the far advanced ocular neurosis in elderly patients, I can ill afford to disparage any approach that offers any prospect of helping this class of people. Perhaps ritualistic suggestion has some application in older people. In my opinion, it is probably harmful in patients under 40.

The fourth principle is that of nipping the ocular neurosis in the bud. This figure of speech is chosen deliberately, for you can nip a bud with your finger tips, while it takes an ax to cut down a full grown tree. Early diagnosis is required, and I have sought to outline how that can be achieved. Being confronted with a budding ocular neurosis, how are we going to nip it? My experience accords with the view of Derby, Duke-Elder, Birge, Harrington, Leinfelder, and others, that reassurance and insight are the essential features of successful therapy. Reassurance is easy to give the patient after a thorough examination. Insight is not so easy to give the patient. Both are important. My experience has been that in young people the examiner, once he is certain of his own ground, usually can bring the patient to the conscious realization that apprehension about the integrity of his visual function was the motivating factor which really brought him to the physician. If this can be achieved, it is not so difficult to take the next step and convince him that ocular symptoms, though far from imaginary, can nevertheless originate entirely in the nervous system without any organic pathology whatever.

The older the patient and the older the ocular anxiety, the more difficult is therapy. Reassurance is always helpful at any stage. The question of whether or not to try to convey insight is certainly a difficult one. My own rule of thumb is this:

In the young, always try. In the old, seldom if ever try. In the middle-aged each case must be decided for itself, and a useful criterion is whether the patient is getting dividends from his neurosis or not. If he (or she) is successfully exploiting the neurosis, an attempt by an ophthalmologist at conveying insight is fairly sure to fail. If, on the other hand, the neurosis is obviously crippling the

patient's life, and interfering with his enjoyment of many good things, then I believe an attempt to convey insight is worth trying.

In patients who obviously come for examination primarily because of ocular anxiety, the question of whether or not to change their lenses will usually arise. The temptation to change the lenses in order to allow the patient to feel less foolish is certainly a strong temptation, and I confess to having succumbed to it more than once. I am coming around to the point of view, however, that if the change is small in degree, it is better not to make it. As a beau geste it is often expedient to give the patient the new prescription, but tell him that the difference from his present prescription is only a small one and not sufficient to make new lenses worth while unless he loses or breaks his present glasses.

Summary

There is no point in summarizing a summary, and on a subject of this scope, with so much left unsaid, this paper itself is only a summary. If compelled to state in one short sentence, however, what I believe to be its essence, it is this:

Examine the patient with psychic photophobia to within an inch of his life and if possible let his glasses alone.

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Discussion

Dr. Kenneth S. Whitmer, Miami: I have certainly enjoyed Dr. Gwathmey's presentation and think his subject is indeed timely in focusing the attention of us modern and ultrascientific ophthalmologists on a facet of medicine that has always plagued us and will ever be present.

His comments will make us pause for a moment and think back on how many ocular neurotics we have mismanaged in recent months, having resorted to the most expeditious course by sending them unhappily on their way with new glasses.

By training, most of us are relatively unskilled in the art of psychiatric history-taking and interrogation. Rarely, for example, is the question of the family history accorded adequate treatment in the questioning of an ophthalmic patient. As Dr. Gwathmey pointed out, a history of blindness in a parent or sibling may be the underlying cause of a profound disturbance of the personality.

Again, in our specialty we have an organ that lends itself well to complete examination, and with the facility we have with diagnostic instruments of precision, we tend to place great emphasis upon findings and data acquired through purely objective diagnostic procedures. As a consequence we think in terms of organic disease and arrive at a diagnosis of functional disorder only secondarily and by exclusion. I am afraid that most of us who perform a large number of refractions every day find that it is much easier to change a pair of glasses than a way of life.

Dr. Gwathmey believes that at least half of the deep-seated ocular neuroses originate in childhood, that children during their impressionable years have been imbued with the fear of blindness. If this is true, I think that it is important that those of us who see large numbers of children should be extremely careful in discussing little John's problems and future before him.

On the other hand, I am impressed with the large number of patients who are suffering from early cataract, glaucoma or macular degenerative conditions in whom some type of neurosis develops. In such cases the problem can certainly be solved at the ophthalmologic level, and great caution must be observed in discussing these findings with patients to avoid aggravation of the neuroses.

During the war I sat on a medical board at 9th Air Force Headquarters, and we attempted to evaluate illness in flying personnel. Most of the organic casualties went through hospital channels, but those of functional origin, flying fatigue and battle neuroses, were channeled through us. Practically all of these men's symptoms were somatic, and at least one out of three had symptoms referable to the special senses, among which the eyes played a dominant role.

If it is true that a great many psychoneuroses run a self-limited course as do other diseases, then the time factor is extremely important. We can understand, therefore, how proponents of some of the allied cults, who may understand the nature of these symptoms, may be so successful in handling them.

In discussing treatment Dr. Gwathmey mentioned insight and reassurance. With his view I am in full accord. I believe that if the patient's symptoms and problems can be looked on sympathetically, and if adequate time is allowed the patient to pour out his apparently never ending series of complaints, if common sense and honest reassurance are used in discussing his conflicts with him, and last, if confidence toward the physician is present, he will in some instances get well.

Dr. Shaler Richardson, Jacksonville: I think Dr. Gwathmey has brought to our attention today a most important phase of ophthalmic practice.

First, I want to mention the neuroses that are brought about by the manner in which we handle our patients. Too often one sees patients well along in years who state that they have consulted other ophthalmologists who have told them that they would lose their sight because of cataracts. Many times these patients have incipient lens changes; their vision is still good, however, and the progress of the cataracts may be slow. It is certainly true that a high percentage of patients above 65 years of age have some evidence of lens changes, and it is also true that a high percentage of them have good or fair vision the rest of their lives. These patients should be reassured and their general health protected. Placebo drops should be used if it is necessary to keep a patient of this type reassured.

Another great fear which may result in a neurosis is the fear of glaucoma when it has existed in other members of the family. Patients apprehensive for this reason should have a most careful examination, including field plottings and tension recording. They should be seen at intervals in order that they may be reassured.

It is not unusual for an ocular neurosis to be occasioned by frustration and fear. I have seen this reaction on numerous occasions in students who have difficulty in meeting certain scholastic standards set up by their parents. They feel frustrated and naturally turn to visual complaints.

Another type of frustration neurosis is occasioned by the overambitious wife whose husband falters in attaining the standard of living she demands for herself and the family. I have under observation a patient of this type who went from one ophthalmologist to another and finally persuaded one that he needed surgery for glaucoma. Trephining was performed, and now he has a hypotonic globe. I had seen the patient over a period of years and had never observed any elevation of tension or any of the other findings of glaucoma.

Dr. Gwathmey mentioned the patient who after a cataract operation labored under the impression that he could not see or was afraid he could not see. I just recently saw a male patient, aged 75, with bilateral cataract. The family of this patient advised against an operation; the family doctor concurred. The patient insisted on the operation, and the intracapsular extraction was performed. Six weeks after the operation the best vision obtained was 20/200. Over a period of months this patient was finally persuaded to read 20/20 without difficulty. I am sure he suffered from a fear complex — the fear that the operation would not result in good vision and that he would be criticized by his family if the outcome was not successful.

In all cases in which we assume a neurosis is present, the patients should have a most comprehensive ocular examination. If we hope to obtain any results with these patients psychologically, we must lay down the foundation in their minds that we have made a most complete study of their ocular condition.

Are Speeding, Open Sirens and Red Light-Breaking By Ambulances Necessary?

LORENZO L. PARKS, M.D.
JACKSONVILLE

This study was prompted by an editorial, written by Dr. C. B. Roesch, which appeared in the November 1952 issue of the Monthly Bulletin of the Duval County Medical Society. This editorial asked several questions, but the main point was that many times ambulances are involved in accidents and the few minutes saved are rarely vital to the patient. Dr. Roesch emphasized among other needs the importance of training ambulance attendants.

From this editorial, and with Dr. Roesch's encouragement, it was decided to make a study of the types of patients brought by ambulance and admitted to the hospitals. At first it was decided to classify the patients transported by ambulance as to their condition. It was found that this approach was not too satisfactory because when the patient came in, the admitting officer was often rushed and failed to keep records on the cases. After a conference with Dr. Edgar Galloway, Medical Director of the Duval Medical Center, it was decided to record on the admitting register those patients admitted by ambulance and state the admitting diagnosis.

Dr. C. C. Hillman, Executive Director of the Jackson Memorial Hospital, Miami, was asked to collect the same data at that hospital. Dr. Hillman has given the following information based on cases in which the patient was brought to the hospital by ambulance during the period January 12 to February 12, 1953:

Total patients brought by ambulance	808
Total patients treated and sent home	428
Total patients admitted to the hospital	247
Total patients sent either to Miami Retreat or to convalescent homes	114
Expired in emergency room	13
Dead on arrival	6

These figures mean that 32.9 per cent of all patients brought to the hospital in ambulances in Miami were admitted to the hospital, and 67.1 per cent were not admitted. The percentage of hospital admissions included those cases in which the patients expired in the emergency room or were dead on arrival. (Dr. Hillman advised me that this evaluation was that of the younger physicians of the house staff.) It was thought that in 99 of these cases there was some justification for using maximum speed on the part of the ambulance driver in transporting patients to the hospital. In other words, 87.8 per cent of the patients arriving by ambulances need not have been rushed to the hospital.

The data that we collected at Duval Medical Center covers the period from February 6 to March 31, 1953, or a period of 53 days. There were 378 patients brought to the hospital by am-

Director, Bureau of Preventable Diseases, Florida State Board of Health.
Read before the Duval County Medical Society, Jacksonville, April 7, 1953.

bulance during this period. Of this number, 108 or 28.5 per cent were admitted to the hospital, and 71.5 per cent were not admitted after a fast ride to the hospital. The number admitted included 3 patients who died within four hours and 11 patients who were dead on arrival. How many of these 11 patients who were dead on arrival might have been saved by first aid?

It was decided to study the admitting diagnoses, which were as follows:

Pulmonary edema (2)
Pneumonia (4)
Acute rheumatic fever (1)
Tetanus (1)
Pregnant — labor (16)
Eclampsia (4)
Threatened abortion (2)
Incomplete abortion (2)
Retained placenta (1)
Pelvic inflammatory disease (2)
Metrorrhagia (1)
Pregnancy with infection (1)
Intestinal obstruction (4)
Miliary tuberculosis (1)
Gunshot wound (3)
Laceration (3)
Nephritis (1)
Diabetes (1)
Leaking duodenal stump (1)
Inguinal hernia (1)
Deferred diagnosis (11)
Burns (1)
Fractured femur (3)
Dislocation and fracture of ankle (2)
Fractured hip (3)
Fractured elbow (1)
Fractured jaw (1)
Fractured spine and fibula (1)
Cerebral hemorrhage (1)
Cerebral concussion (1)
Massive cerebral injury (1)
Cardiac failure (1)
Acute heart failure (1)
Myocardial infarct (2)
Head injury (3)
Paralytic ileus (1)
Sleeping tablet ingested (1)
Ingested ammonia (1)
Bichloride of mercury poison (1)
Urinary extravasation (1)
Peptic ulcer (1)
Osteomyelitis (1)
Appendicitis (2)

It is most difficult to state the condition of the patient simply from the admitting diagnosis; however, if we were to judge from the diagnosis alone whether the case was an emergency or not, I believe we might be justified in accepting few of the cases as emergencies. If we were to accept all cerebral hemorrhages, head injuries, heart failure cases and gunshot wounds as emergencies, we would be inclined to think that only 16 of the 108 cases in which the patients were admitted at Duval Medical Center could possibly be called emergencies. I believe that we are being rather conservative in including the 2 cases of gunshot wound of the shoulder and arm. This tabulation means that possibly 15 per cent of the total number of cases in which the patients were hospitalized might be classified as emergency cases; thus, only 4.2 per cent of all cases in which the patients were transported by ambulance to the hospital might possibly be called emergencies. In other words, are we safe in saying, from these figures, that only 4 or 5 ambulance cases out of every 100 are emergencies?

It is interesting to note that 6 of the patients brought to the hospital in an ambulance departed before they were seen by the physician. There seemed to be no difference between the number of patients admitted at night as compared with daytime admissions. We will not discuss the mental disturbances that a fast ride to the hospital could cause the patient to experience, or at least certain types of patients.

We have conferred with the State Department of Public Safety in Tallahassee, and they advise us that in 1951, as far as their records go, ambulances were involved in 25 accidents throughout the state. From these ambulance accidents there were 14 persons injured and one death. The ambulances were in traffic violation thirteen times and not in violation twelve times.

We have had correspondence with several other state health departments and several cities in an effort to learn, if possible, what the traffic regulations are. It seems that they vary from city to city, but apparently most of them do limit the speed of the ambulance, although the regulation is seldom enforced. Sirens seem to be permitted in most places. The responsibility is placed upon the ambulance driver in running through the red light. The driver is expected to have his ambulance under control and at such a speed that he can avoid an accident if he does run through a red light.

We had a check made on the number of ambulances rushing to Duval Medical Center with sirens open. We found over a period of 12 days from 8:30 a.m. to 10:30 p.m. that out of 70 cases in which the patient was brought to the hospital by ambulance during this period, in 37 instances the ambulance was speeding in the block of the hospital. In the same number of instances the siren was open, and in 10 it remained open until arrival at the hospital emergency room. No doubt there were more, but we obtained a record of only this number. It is noteworthy that four different ambulance companies were the primary offenders in speeding at the hospital with open sirens, and of these four, one was the Jacksonville city police ambulance.

We conferred with only two ambulance companies and were advised that the ambulance drivers were not required to hold a first aid or Red Cross first aid card, but many of them did hold them.

It seems that Jacksonville has a problem which probably can be remedied appreciably. If an accident occurs in some part of the city, frequently more than one ambulance responds to the call. This practice means that many ambulance rush trips are not necessary. Naturally, the ambulance companies are in competition with each other, as they are looking for business.

Since we began collecting this material we have had several newspaper clippings brought to our attention. We have one from Greenville, S. C., in which the writer is complaining about the fast ambulances and traffic hazards. A clipping from the Commercial Appeal in Memphis claimed that a woman was killed by a speeding ambulance and that the patient who was being carried in the ambulance was not seriously ill. A clipping from one of the Miami papers was forwarded to me by Dr. Hillman in January, at which time six persons were injured when an ambulance and a car collided. Most of you will recall that a new Jacksonville police ambulance was in a crash here a few weeks ago. It was reported that the patient had a head injury from a fight, but, apparently it was not an emergency case. I was unable to get any figures from Jacksonville on the number of ambulance accidents, but I think most of you will recall that an expectant mother was killed in an ambulance accident on the Riverside viaduct in the latter part of 1952.

It is apparent from the data we have collected that it is difficult to say positively that ambulances should not be permitted to break through red lights and travel at excessive speeds. It is believed that if the ambulances were required to observe normal speed limits and not be permitted to break through red lights or use sirens, the number of lives lost by observing normal traffic regulations probably would not be more than the number of persons injured and killed at the present time by speeding ambulances.

Recommendations

A. Ambulance drivers should be required to hold Red Cross First Aid Certificates.

B. Ambulances should not be permitted to run through red lights nor travel at an excessive speed except for certain conditions. It is suggested that a committee from the medical society decide upon what conditions would permit excessive speed, such as bichloride of mercury poisoning and possibly cardiac disease.

C. There should be an educational program for the ambulance companies to see that they use some judgment in what cases require excessive speed.

D. It is recommended that an ambulance service system be organized whereby all ambulance calls could come to one telephone number and that the ambulance companies be called upon on an alternate basis, depending upon their location.

E. It is recommended that the medical society go on record urging that our cities enforce the ordinance in regard to speed of ambulances and that the ambulance drivers be required to observe the regular traffic regulations.

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The Scientific Department of The Journal

Reflects the Experience of You and Your Colleagues

Detection and Management of Retrolental Fibroplasia: A Plan for the Average Hospital and Staff

Curtis D. Benton, Jr., M.D.
Fort Lauderdale

In recent years, retrolental fibroplasia has become the commonest cause of blindness in preschool children. It is especially urgent that physicians become interested in this condition because of the possibility that in our enthusiasm to provide increasing facilities for the care of premature infants we may, in certain cases, actually be causing this disease. Its importance is further emphasized to us by the fact that 25 cases in the Dade-Broward area were serious enough to have been brought to the attention of the Florida Council for the Blind.

Retrolental fibroplasia, as a clinical entity, was first described and its relation to prematurity recognized in 1942 by Terry.[1] Seven years elapsed before Owens and Owens[2] described the entire course of the disease and proved its postnatal character.

Retrolental fibroplasia is invariably a bilateral condition and it occurs almost exclusively in premature infants weighing less than 4 pounds. The incidence has risen from nearly nothing before 1940 to as high as 80 per cent in recent reports from some hospitals, the usual percentage being around 30 per cent to 40 per cent. The disease is never present from birth and rarely becomes detectable before the age of 3 weeks. The condition almost never begins after the age of 3 months. There is no difference in incidence between the two sexes.

Method of Examination

Every premature infant whose weight is under 4 pounds at birth should be selected for ophthalmoscopic examinations. The initial examination is made when the infant is 2 weeks old and re-examinations are made every other week in cases in which there is negative evidence and every week or more often in cases in which retinal changes are observed. The pupils are dilated with a mixture of 4 per cent homatropine and 1 per cent Paredrine® solutions instilled at one hour and again 55 minutes before the time set for examination. It is best to examine the infants at feeding time, and a nursing bottle of milk given to the baby will greatly improve his cooperation. The use of an electric ophthalmoscope is essential.

Retinal Changes

The observer must be aware of the several differences between the eyes of premature infants and adults. These normal characteristics, as listed by Tyner,[3] include (a) haziness of the ocular media, (b) pallor of the optic disk, (c) enlarged retinal veins, and (d) a gray color of the peripheral retina. It is normal for the outer one fourth of the visible retina to appear dull gray. No choroidal markings are apparent in this area, but the retinal vessels undergo no change as they pass from the posterior red fundus onto the gray zone. It is most important to learn the normal appearance of the peripheral gray retina because many of the important early changes of retrolental fibroplasia occur at this border. Another factor impairing clear visualization of the fundi of premature infants is the presence of remnants of the absorbing pupillary membrane. This was noted in 12 per cent of the patients reported in this study. Likewise, retinal hemorrhages are present in about 5 per cent of normal premature infants.

The active phases of retrolental fibroplasia progress through several stages. Five different stages were classified by Reese and his associates,[4] but they failed to include the important preretinal membrane. A modification of Reese's table is thus suggested as follows:

Stage 1. Tortuosity of the retinal vessels plus neovascularization.

Stage 2. Stage 1 plus dilatation of retinal vessels and early membrane formation.

Read before the Broward County Medical Society, Fort Lauderdale, Nov. 18, 1952.

Stage 3. Stage 2 plus well developed membrane formation and early retinal detachment.

Stage 4. Extensive membrane formation and moderate retinal detachment.

Stage 5. Complete retinal detachment and retrolental membrane.

Superficial retinal hemorrhages usually in the midperiphery may be present in stages 1, 2 and 3. Dilatation and tortuosity of all the retinal arterioles and veins may become severe in stages 2 and 3. The neovascularization is usually first seen as a brushlike group of small vessels bordering on the grey area. The preretinal membrane is the result of an angioblastic process extending into the vitreous from the inner retinal layers as shown in pathologic reports by Reese and Blodi,[5] Tyner and Frayer,[6] and others. The formation of the preretinal membrane is a fascinating condition to observe. It is usually sufficiently transparent to allow visualization of the underlying retina. New blood vessels extend onto the membrane and grow with it. The earliest and most extensive changes usually occur in the upper temporal portion of both retinas. It is fortunate that they do because this area is the one most easily observed in most infants.

The retinal changes of stages 1 and 2 are completely reversible and indeed often spontaneously disappear. Some regression is possible in stages 3 and 4. For any treatment to be particularly helpful it must be begun before stage 3 has become well established. The great tragedy of retrolental fibroplasia is that in many cases it is not detected until the retinal detachment is complete and can be seen even by the parents of the child.

After the disease has run its course and the lesions have healed, again certain grades can be recognized. The classification of Reese and his associates[4] is as follows:

Grade 1. Pale appearance of the fundus with attenuated blood vessels.

Grade 2. Grade 1 plus small mass of opaque tissue in periphery with or without visible small retinal detachment.

Grade 3. Large mass of opaque tissue in periphery incorporating a retinal fold which extends to the disk.

Grade 4. Retrolental tissue covering part of the pupillary area.

Grade 5. Retrolental tissue covering entire pupillary area.

Etiologic Possibilities

LIGHT. — The possible toxic effect of light upon the retina of the premature infant was considered as a cause of the condition. Locke and Reese[7] occluded both eyes of 33 infants within 24 hours after birth. All light was occluded until the time of the infant's discharge from the hospital. In 15 infants, or 45 per cent, there were signs of the acute phase of the disease at the first examination. No additional cases were detected on follow-up study. A control group of 33 infants whose eyes were not occluded were examined at weekly intervals; in 16, or 47 per cent, acute phases of the disease were present. The severity of changes was also equal in the two groups. Another group of 22 infants had one eye occluded from birth to the time of discharge from the hospital. Signs of retrolental fibroplasia developed in 10, or 45 per cent, of these infants. The changes were equal in both eyes of each afflicted child.

DIET. — (1) Vitamin A: For a 16 month period at the Bellevue Hospital, infants were given vitamin D as the only routine vitamin supplement. During the next 14 months all infants were given routinely a multivitamin containing vitamin A as well as D. The incidence of retrolental fibroplasia remained the same in both periods.[8] (2) Vitamin E: Kinsey and Chisholm[9] reported the vitamin E blood level not below normal in premature infants. A group of 55 premature infants was given vitamin E, 50 mg. three times daily prophylactically. Thirty-one infants, or 56 per cent, showed acute changes at some time in their hospital stay. Therapeutic administration of the same vitamin to 46 others with the acute disease was carried out, but did not appear to influence the outcome. In one pair of twins the disease developed with parallel severity with one receiving vitamin E and the other not. LaMotte, Tyner and Scheie[10] reported that retrolental fibroplasia developed in 10 of 30 infants receiving 50 mg. of vitamin E three times daily as prophylaxis. (3) Iron: Kinsey and Chisholm[9] at the Boston-Lying-In Hospital substituted vitamins D and C for a previously routine multivitamin and iron for a period of time and noted that the incidence of retrolental fibroplasia was equal in the two periods.

ANEMIA. — Retrolental fibroplasia has been thought to be due to anemia on the one hand and to the effect of blood transfusions on the other. Neither, however, seems to be an important factor.

Adrenal Cortical Hormone Deficiency. — Reese and Blodi[5] in 1951 reported findings of ACTH deficiency in premature infants. This plus the known effect of ACTH in inhibiting neovascularization suggested its use in retrolental fibroplasia. ACTH, 20 to 25 mg. daily, given to 14 babies for 14 days gave encouraging results. A later report[4] quieted the earlier enthusiasm. In 1950, 34 infants were treated; 14 served as controls. Blindness resulted in 12 per cent of those treated and in 71 per cent of those not treated. In 1951, 30 infants were given the same treatment and 36 were not. The result was blindness in 33 per cent of those treated and in 19 per cent of controls. For the two year period, therefore, the results were almost equal in the treated and untreated groups. LaMotte, Tyner and Scheie[10] treated 19 babies with retrolental fibroplasia with ACTH and 2 with cortisone. The results were discouraging. Three became blind in one eye and 9 in both eyes.

Oxygen.—Szewczyk[11] reported that the early changes of retrolental fibroplasia could invariably be reversed with concentration of oxygen of 65 to 70 per cent and that changes could be made to reappear in 24 to 48 hours by withholding oxygen. Campbell[12] in Australia and Crosse and Evans[13] in England, however, were of the opinion that excessive use of oxygen causes the disease. Campbell[12] observed retrolental fibroplasia in 19 per cent of 123 infants in a hospital where oxygen was given freely prophylactically as well as for cyanosis. In another group of 58 infants receiving oxygen only as needed for cyanosis, the incidence was 7.1 per cent. Cross and Evans[13] reported that retrolental fibroplasia developed in 8 per cent of 96 infants observed during a period when oxygen was given freely and often. Thereafter oxygen was restricted to minimal doses for the shortest possible periods, and the disease did not occur in any of the 65 infants examined.

Personal Observations

At the Crawford W. Long Hospital in Atlanta, 84 infants weighing 4 pounds or less were examined. The acute phase of the disease was observed in 16 (19 per cent) of these infants, and suspicious changes were noted in another 8 (9 per cent). Six additional patients were treated at the Grady Memorial Hospital in the same city. One patient was given ACTH, 1 cortisone, 3 cortisone and oxygen, and 13 oxygen only; 4 were given no treatment because the disease was mild.

ACTH. — The 1 infant given ACTH weighed 1 pound 12 ounces at birth. Stage 1 of the active disease was observed at the age of 8 weeks. ACTH, 20 mg. a day, was given for three weeks, then 10 mg. a day for two weeks. There was complete return of the retina to normal.

Cortisone. — In 1 infant weighing 3 pounds 1 ounce at birth the disease developed at the age of 12 weeks and had progressed to stage 3 before treatment was begun. Cortisone, 80 mg. a day, was given for six weeks. The final result was grade 2.

Cortisone and Oxygen. — Three infants weighing from 2 pounds 5 ounces to 3 pounds 2 ounces were treated. In each case the disease was in stage 4 at the onset of treatment. They were treated for three to five weeks. One improved to final grade 1, one improved slightly to final grade 3, and the other remained in grade 4.

Oxygen. — Thirteen infants were treated with high concentrations of oxygen (60 to 70 per cent)* for varying lengths of time and at various intervals to observe some of the effects of this agent upon the disease. Birth weights ranged from 1 pound 11 ounces to 3 pounds 13½ ounces. In most instances the initial examination of the fundus revealed normal findings. The development of the early retinal changes was observed to begin any time from the third to the twelfth week of life. In 3 infants receiving oxygen since birth the disease developed while they were still in oxygen. About one half of the remaining 10 patients had been in oxygen at some time prior to the development of retinal changes and the rest had not been in oxygen before the disease was detected.

Definite improvement in the condition was observed in 5 of the infants treated with oxygen. In 2, the condition was seen to become definitely worse when oxygen was suddenly discontinued and to improve again upon reinstitution of oxygen therapy. In both, the disease was limited at the time to stage 1 or 2. The only pronounced changes observed were those of the caliber and tortuosity of the retinal vessels, peripheral hemorrhages and neovascularization. In no instance in which a definite membrane was forming did oxygen therapy or its withdrawal result in any rapid change. Oxygen therapy is definitely not a certain cure for retrolental fibroplasia in any stage as evi-

*Measurements with an oximeter showed that in the Armstrong incubator a minimum of 6 liters of oxygen per minute would give a level of 60 to 70 per cent. It is difficult to gain higher concentrations even with twice this amount of oxygen.

denced by the fact that the disease may develop while an infant is in an atmosphere of high oxygen concentration and also by the fact that 3 of the infants in this series who were given oxygen as therapy continued to have progressive retinal disease and were left with moderate to pronounced visual loss. In 4 infants with mild changes (stage 1) the eyes reverted to normal with no treatment, but they cannot be considered as controls because had the condition continued to get worse, some type of treatment would have been given.

As regards the role of oxygen in the causation or treatment of retrolental fibroplasia, it appears that there is some basis for both schools of thought on the problem. It is possible that tissue anoxia plays an important part in the development of the retinal changes, but that this anoxia may be relative as well as absolute. In many cases the disease seems to be the direct result of the sudden return of an infant to room oxygen levels from a previous high incubator oxygen level. In other cases it has developed when pneumonia or infection developed and there was deficiency in blood oxygen saturation. An increase in oxygen of the infants' inspired air will in some cases improve the retinal changes, but in others no benefit is apparent.

Until further reports are forthcoming from controlled studies on large series of cases, it is imperative to proceed with caution when changing the oxygen environment of a premature infant. All changes should be slow and gradual and accompanied by repeated ophthalmoscopic observations.

In the light of present knowledge, the treatment of cases of retrolental fibroplasia is suggested as follows:

1. Any infants receiving oxygen therapy for cyanosis should be brought down to room oxygen levels gradually.

2. Infants, not in oxygen, in whom definite stage 2 of the disease develops, should be placed in an environment of 50 to 60 per cent oxygen. This can be obtained by a flow of 6 liters per minute in the Armstrong incubator.

3. Should the disease progress to stage 3 while the infant is receiving oxygen, cortisone in doses of 80 mg. per day should be given for three to five weeks.

4. If improvement of the condition occurs with oxygen therapy, the infant is gradually returned to room atmosphere over a three to five week period.

Cooperative Management

Retrolental fibroplasia is a condition that requires close cooperation between the pediatrician and the ophthalmologist. Its incidence in premature infants is at least 20 per cent, for it occurs far more commonly than any other abnormality the infant may have, and it is certainly one of the most serious diseases. Treatment, if it can be of any benefit, must be started when the disease is in its earliest stages. The only way to detect these early changes is for repeated careful ophthalmoscopic examinations to be performed on every infant weighing less than 4 pounds by an ophthalmologist either experienced in this procedure or willing to devote enough time to learn to overcome the difficulties of such an examination. One should never allow this condition to develop to the stage of complete retinal detachment before it is detected and then be faced with the difficult task of informing parents that their child has become hopelessly blind with no attempt having been made to prevent the blindness.

Proposed Plan for the Average Hospital and Staff

1. Each obstetrician should make every effort within the limits of safety to carry his patients to a full term delivery.

2. The obstetrician should attempt to keep fetal anoxia to a minimum and he should use supplemental oxygen only when indicated.

3. The pediatrician must recognize his obligation to the patient and the parents to recommend that ophthalmoscopic consultation be permitted.

4. An authorization certificate for consultation should be posted in the nursery and signed by each cooperating pediatrician. It may state: "Permission is granted to the physician designated upon the order sheet of the chart of each of my premature infant patients for that physician to perform such ophthalmoscopic examinations upon the specified patient as he deems necessary. Reports of these examinations are to be recorded properly on each chart along with recommendations for treatment."

The pediatrician then designates the ophthalmologist of his choice, and the nurse in charge may notify the ophthalmologist of the infants he has been requested to examine.

5. Each ophthalmologist should agree to perform the examinations regularly and carefully. The fees for such examinations should be made known to the pediatrician so that he can inform

parents of the approximate expenses should the parents demand to have such information when told of the desired consulting service.

6. The opthalmologist should record his findings in clear and understandable terms.

7. Decisions for treatment should be made only after agreement by both ophthalmologist and pediatrician.

8. It should be the responsibility of the pediatrician to give the parents whatever information he believes advisable concerning the condition of the infant's eyes. In all serious cases the parents will usually insist upon talking with the ophthalmologist, and rightfully so.

9. The pediatrician and the ophthalmologist should agree about the discharge of the infant from the hospital and the schedule of their follow-up visits.

With such a system, any hospital and staff handling even a small number of premature infant patients can offer the best possible service to their patients and community.

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Sarcoidosis of the Myocardium
Report of a Case

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Surprisingly few articles are found in the English literature on the subject of sarcoidosis of the myocardium, or for that matter, on the subject of granulomatous disease of the myocardium in general, considering the scope and immensity of the field encompassed.

My attention was first directed to this problem years ago when I had occasion to observe several cases of acute brucellosis. Cardiac findings were rather striking in that in a series of 5 cases, auricular fibrillation was present in 2 and electrocardiographic changes in 3. The thought suggested itself at that time that possibly cases ordinarily considered rheumatic in origin might actually be merely instances of healed brucella endocarditis or the residual of myocardial involvement by brucellosis. Unfortunately, in the absence of postmortem material, this thought could not be confirmed or disproved, but a review of the literature subsequently failed to produce any corrobative evidence. It must be admitted that up to the present time, there is little in the literature which would corroborate such a viewpoint. Subsequent to observing the cases of brucellosis I had occasion to observe a case of Boeck's sarcoid in a Negro man, which led me to review the literature and report the case here.

Review of Literature

In an excellent article on sarcoidosis involving the heart, Scotti and McKeown reviewed the literature up to the date of publication and presented a summary of 13 cases confirmed by autopsy. In table 1 I have included their table and added to it 4 proved cases, confirmed by autopsy, reported in the literature since that date, as well as my case. Considered, but not included in this table, are case 11 of Ricker and Clark and case 53, that of a 47 year old Negro man, reported by Riley.

Table 1.—Sarcoidosis Involving the Heart: Cases in Which Autopsies were Performed*

Author and Patient	*Clinical Evidence of Cardiac Involvement*	*Cause of Death*	*Lesions of Heart*	*Lesions of Other Organs*
Bernstein et al, 52 yr. white man	None (dyspnea due to respiratory disease and hydrothorax)	Bronchopneumonia	Epicardium	Skin, bronchial mucosa, intestinal mucosa
Schaumann, 45 yr. white man	Congestive heart failure (due to cor pulmonale and possibly to cardiac lesions)	Cardiac failure (due to cor pulmonale and possibly to cardiac lesions)	Epicardium	Lungs, liver, spleen, skin, lymph nodes, tonsils, bone marrow, tendon sheaths (hand), capsule of kidneys
Nickerson, 58 yr. Negro woman	None (dyspnea due to pleural effusion)	Acute overwhelming sarcoidosis	Parietal pericardium, myocardium, subendocardial fibrous tissue	Parietal pleura, lungs, liver, lymph nodes, spleen, eyelid
Spencer and Warren, 51 yr. man	None	Obstruction of airway (edema of larnyx)	Myocardium	Lungs, skin, liver, spleen, lymph nodes, kidneys, trachea, thyroid gland
Cotter, 18 yr. Negro man	Progressive myocardial failure	Sarcoidosis of heart	Myocardium Endocardium	Lungs, lymph nodes, liver, spleen, alimentary tract, subcutaneous tissue and underlying muscle, testis
Longcope and Fisher, 40 yr. Negro man	None known	Sarcoidosis of heart — death sudden	Pericardium Myocardium	Lymph nodes, lung, liver, kidneys, spermatic cord, cerebral dura, skin (penis)
Longcope and Fisher, 42 yr. Negro man	Stokes-Adams syndrome, auriculoventricular dissociation	Suicide	Pericardium Myocardium	Pleura, lungs, spleen, liver, kidneys
Longcope and Fisher**	None		Myocardium	
Johnson and Jason, 24 yr. Negro man	Premature ventricular beats; ventricular tachycardia and severe congestive heart failure	Sarcoidosis of heart	Epicardium Myocardium Endocardium	Visceral pleura, lungs, spleen, lymph nodes, liver, testis
Skavlem and Ritterhoff, 42 yr. white man	None (dyspnea related to lesions of lungs)	Respiratory failure (coexistent asbestosis and sarcoidosis)	Myocardium	Lungs, lymph nodes, spleen, liver, kidneys, diaphragm
Hauser, 27 yr. Negro woman	Progressive dyspnea (respiratory and cardiac; cor pulmonale)	Respiratory and cardiac failure (cor pulmonale)	Pericardium	Lungs, bronchi, pleura, spleen, right kidney, lymph nodes
Bates and Walsh, 31 yr. Negro man	Persistent tachycardia	Sarcoidosis of heart — death sudden	Myocardium Epicardium	Lungs, liver, kidneys, spleen, tracheobronchial lymph nodes, voluntary muscles
Scotti and McKeown, 26 yr. Negro man	No accurate history, but apparently no symptoms. Said to have had "pain around heart" once	Sarcoidosis of heart — sudden death	Myocardium Epicardium	Lymph nodes, lungs, liver, prostate

Table 1.—Sarcoidosis Involving the Heart: Cases in Which Autopsies were Performed* — *(Continued)*

Author and Patient	*Clinical Evidence of Cardiac Involvement*	*Cause of Death*	*Lesions of Heart*	*Lesions of Other Organs*
Ricker and Clark, 25 yr. Negro man	Recurrent ventricular tachycardia	Sarcoidosis of heart	Myocardium	Pituitary, thyroid, lungs, lymph nodes, liver, spleen, pancreas, kidneys, prostate, epididymis, brain, meninges, retina and skeletal muscles
Kulka, 26 yr. Negro woman	None	Acute cardiac failure — death sudden	Myocardium	Lungs, spleen, mediastinum, lymph nodes, kidneys, thyroid, adrenals and pituitary gland
Yesner and Silver, 51 yr. white man	Cardiac enlargement, presystolic gallop rhythm, palpable liver and other signs of congestive failure	Cardiac failure	Myocardium Pericardium	Lungs, lymph nodes, spleen, liver, pancreas and thyroid
Adickes, Zimmerman and Cardwell	Chronic progressive myocardial failure; recurring arrhythmia consisting of multifocal systoles with prolonged runs of ventricular tachycardia	Sarcoidosis of heart	Myocardium	Lungs, tracheobronchial lymph nodes, liver and spleen
Sales, 20 yr. Negro man	Progressive and persistent cardiac failure despite digitalis and diuretics	Vascular collapse	Myocardium Pericardium	Mediastinal lymph nodes

*Table modified from Scotti and McKeown
**Details not given in article

Case 11 of Ricker and Clark is not included, despite the authors' statement that typical sarcoid granulomas were found densely seeded in the lungs, lymph nodes, heart, liver, spleen, kidneys and skeletal muscles, because of the statement that, in addition, tuberculous lesions were present in some of the organs and acid-fast rods were found in material taken from the right pulmonary apex. Under the circumstances, this case appeared to be too equivocal for inclusion. Case 53 of Riley is also not included for a similar reason, namely, that while the clinical course and pathologic report in most other respects definitely suggested Boeck's sarcoid, the microscopic examination of the heart revealed miliary granulomas, typically epithelioid in nature and containing lymphocytes, but with many of the lesions showing areas of central breakdown indistinguishable from caseation necrosis and numerous Langhan's type giant cells. No acid-fast bacilli, however, were found.

The clinical features and pathology of Boeck's sarcoid are too well known and too thoroughly covered in various textbooks on medicine to need review here. It may not be amiss, however, to mention a few of the findings of experienced investigators relative to cardiac involvement in Boeck's sarcoidosis. In Riley's series of cases, exclusive of those cases in which cardiovascular disease of known cause was present, the only consistent cardiac finding was tachycardia, which was present in 21 cases, or 40 per cent. Accentuation of the pulmonic second sound was noted in 16 cases. Although not an unusual finding in the younger age group under consideration, in several cases in which there were pulmonary lesions, it was markedly accentuated, suggesting some degree of pulmonary hypertension. Systolic, precordial and pulmonic murmurs were present in a few instances. Electrocardiograms were made in 17 cases, without clinical evidence of unrelated cardiovascular disease, and were normal in 15. In 2 cases the electrocardiogram showed evidence of right ventricular strain, secondary to extensive pulmonary changes. Reisner, in his article on sar-

coidosis, stated that the heart may become involved in two ways: either through direct invasion by sarcoid tissue, particularly of the myocardium, or indirectly as a result of extensive pulmonary changes of long standing which may eventually cause failure of the right side of the heart.

Scotti and McKeown, after careful dissection of the coronary arteries in their case, found no obstructive lesions, either at the orifices or along the course of the vessels, to account for the myocardial fibrosis. One of the granulomatous nodules was adjacent to a branch of the coronary artery, but did not compress the vessel. Despite many sections taken to determine whether there was any obstruction of the arteries elsewhere due to sarcoid nodules, none was detected; nor was there any evidence in the gross or histologic material to indicate rheumatic fever or syphilis as a cause of the fibrosis. These authors attributed the sudden death in their case to the active lesions extensively involving the myocardium along with the prominent fibrosis. Similar findings were reported by Longcope and Fisher, and also by Bates and Walsh, in whose case, at autopsy, sarcoid lesions were found throughout the myocardium in both ventricles, the interventricular septum and the papillary muscles associated with fibrosis.

In brief, then, the consensus among the authors who have investigated this subject is that death, when it occurs in cardiac involvement by sarcoidosis, is usually due to extensive infiltration of the myocardium, with resultant fibrosis and, most frequently, cardiac failure.

Report of Case

A 20 year old Negro man, hospitalized on Aug. 9, 1948, complained of abdominal distention; cough, productive of minimal amounts of white, frothy sputum, but no hemoptysis; episodes of nocturnal dyspnea and orthopnea; and weakness of 1½ months' duration. Intermittent pedal edema was first noticed about two weeks prior to admission. Thereafter, the patient had mild anorexia and experienced some febrile episodes. There was a 10 pound weight loss in a period of one month. There was no vomiting. Stools were normal. The patient gave a history of having had an acute iritis in 1947, while in service in Korea, at which time a lymph node biopsy was made, and he was told that he had Boeck's sarcoid. He denied venereal disease by name and symptom, but claimed he had episodes during which his joints became hot, swollen and tender, the knee and ankle joints being the ones mostly involved.

Physical Examination: The patient was a well developed, fairly well nourished Negro man, sitting in a chair, in no apparent distress. He was not noticeably cyanotic or anemic, and was well oriented and alert. There was a 1 inch, well healed cervical scar on the left with no unusual adenopathies present. The blood pressure was 110 systolic and 75 diastolic bilaterally. The pulse rate was 100 and regular. Sinus tachycardia was present. The pulmonic second sound was greater in intensity than the aortic second sound. A grade 2, blowing, systolic murmur was heard maximally in the apical area. No diastolic phase could definitely be detected. The cardiac margin was enlarged beyond the anterior axillary line in the fifth intercostal space. No aortic murmurs were noted.

Laboratory Examinations: On admission, the complete blood count was red blood cells 5,080,000, white blood cells 4,600, hemoglobin estimation 95 per cent (Sahli), polymorphonuclears 40, lymphocytes 52, monocytes 5, eosinophils 3. The malaria smear was negative. The sedimentation rate was 6 mm. at the end of one hour. Routine urinalysis gave entirely negative results, as did the Kahn test. The serum calcium was 9.6. The repeat sedimentation rate was 4. Serum protein partition was total proteins 10.96, albumin 4.45 and globulin 6.51.

A roentgenogram of the chest gave evidence of normal bony framework, with the cardiac silhouette enlarged in the transverse diameter, showing accentuation of the left auricular curve and increased rounding of the apex. The aortic arch was normal, and the trachea was in the midline. Both lung fields showed a moderate degree of hypervascularity in the hilar region and at both bases. The domes of the diaphragm and costophrenic angles were normal. The transverse cardiac diameter was 16.9 cm., compared with a predicted normal of 12 cm., according to the Hodges-Eyster formula. Examination of both hands revealed pinhead-sized areas of well demarcated osteolysis at the middle phalanx of the left index finger, the distal phalanx of the left middle finger and the middle phalanx of the right index finger. An electrocardiogram showed myocardial damage.

Course in the Hospital: The course was afebrile until the patient expired. Following admission, he was kept semiambulant upon ward without ill effect and without complaints. On the morning of August 18, however, he complained of mild dyspnea and was advised to stay at bed rest. Shortly before noon, he had a sudden episode of severe dyspnea with coughing, productive of about a cupful of blood. The dyspnea continued to increase, and he was placed at absolute rest in an oxygen tent and at the same time placed on the seriously ill list. At this time, rapid digitalization was carried out with the combined use of digitalis orally and lanatocide C intravenously. About 2 p.m. complete vascular collapse occurred, with the patient moaning and yelling. Sedation was then increased. In spite of this therapy and what supportive measures could be taken, he failed to rally from the state of vascular collapse, and for the last 12 hours prior to death, no pulse or blood pressure could be obtained. He expired at 9:40 a.m. on August 19.

Final Diagnosis: Heart disease, etiology Boeck's sarcoid, as manifested by cardiac enlargement, myocardial damage, mitral insufficiency and myocardial insufficiency, terminating in an acute bout of left ventricular failure, treated, patient expired.

Postmortem Examination.—Gross Pathology: The body was opened by a supramammary "T" incision. Approximately 500 cc. of reddish brown fluid was found within the pleural space, and about 200 cc. of clear straw-colored fluid was in the abdominal cavity. The heart was pushed up and appeared greatly enlarged. There was a large mass of glands within the mediastinal area, ranging in size from 2 to 6 cm. in length. The other organs occupied their usual relationship and were within normal limits.

Viscera. — Heart: The heart weighed 600 Gm. The valve measurements were as follows:

Aortic: 6 cm.	Pulmonary: 6.5 cm.
Mitral: 7.5 cm.	Tricuspid: 8 cm.

The myocardium of the right ventricle measured 1.1 cm. and that of the left measured 2 cm. On the anterior surface of the apex of the left ventricle there was a shaggy, greyish area on the epicardium measuring 1.2 cm. in diameter. This was not attached to the pericardial sac. The valves showed minimal thickening, but the aortic valve appeared to be stenotic, admitting only the tip of the index finger. The chordae tendineae and papillary muscles were flabby. The cut surface of the myocardium

showed it to be infiltrated throughout by greyish white masses homogenous in structure with the musculature, which was a pale pink. The coronary vessels were patent throughout. The mediastinum contained a mass of dusky red tracheobronchial nodes arranged in clusters and extending 15 cm., beginning 1 cm. above the bifurcation of the trachea. These glands measured in size from 2 to 6 cm. and their cut surface showed central pink with radiating sun-ray-like striation toward the periphery. Frozen sections of these nodes presented the typical picture of Boeck's sarcoidosis.

Lungs: The left lung weighed 800 Gm. The right lung weighed 600 Gm. They were crepitant and air-containing throughout. There was a slight pulmonary edema present.

Liver: The liver weighed 1,500 Gm. and was unchanged in shape. It was smooth and purplish red. The cut surface varied from tan-brown to areas flecked with yellow, presenting the typical picture of nutmeg liver. Thin sections were easily obtained.

Microscopic Description. — Heart: The myocardium showed infiltration by numerous zones of round epithelioid cells, among which were numerous giant cells. These zones of infiltration acted as a replacement of the normal myocardial musculature.

Lungs: There was passive congestion of considerable degree with lobular areas of atelectasis. Tracheobronchial lymph nodes showed many areas morphologically similar to noncaseating tubercles in which there was an occasional giant cell. The architecture of the gland had been wholly replaced by this infiltration.

Liver: Normal architecture had been disturbed to the extent that in the periphery of the bile duct the cells had lost their staining characteristics, and some zones appeared to be almost wholly acellular. There was considerable round cell infiltration about the bile duct.

Kidneys: The kidneys showed chronic passive congestion.

Microscopic Diagnosis:

1. Chronic myocarditis (infiltration by sarcoidosis of Boeck).
2. Boeck's sarcoidosis of tracheobronchial lymph nodes.
3. Passive congestion of lungs.
4. Focal necrosis of liver.

Note: Acid-fast stain failed to reveal tubercle bacilli in either tracheobronchial lymph nodes or the area of infiltration into the myocardium.

Summary

An additional case of Boeck's sarcoid involving the myocardium is described, bringing to 18 the total number of such cases reported in the literature.

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MEDICAL DISTRICT MEETINGS

St. Augustine, Oct. 19, 1953

Tallahassee, Oct. 20, 1953

Tampa, Oct. 21, 1953

West Palm Beach, Oct. 22, 1953

Sprains and Strains Treated With the Ultrafaradic M-4 Impulse Generator

GEORGE R. CRISLER, M.D.
With the Technical Assistance of Dorothy Mason
WINTER PARK

During the last two years we have used the Ultrafaradic M-4 Impulse Generator®[1] in the treatment of 804 patients. In this study we are reporting our results in acute sprains and strains, including charleyhorses, encountered among the first 400 cases. Many of the injuries were incurred in football. Some of them were temporarily incapacitating; others were mild, but all were severe enough to prevent full time occupation. Some of the patients had been treated by other methods and were given "ultrafaradic" physiotherapy only after unsatisfactory response to the previous measures. No other treatment was given concurrently with the exception of aspirin in an occasional case.

Apparatus and Methods

The Ultrafaradic Impulse Generator is a device for stimulating nerves and muscles by means of controlled electric shocks. The output of the apparatus is a series of impulses in the form of condenser discharges. The constants of the circuit, which includes the body of the pateint, are such that each impulse has a duration of only a few microseconds. The impulse repetition rate and the voltage can be controlled by the operator, the rate ranging from about 4 to 30 per second, and the voltage from 0 to 300.

Figure 1 is a schematic diagram of the circuits of the generator. Figure 2 is a photograph of the equipment.

In preparing for a treatment, the indifferent electrode is connected to the patient at some broad contact area remote from the area to be treated so that when the active electrode is applied, the impulses will flow through the tissues between the two electrodes. The voltage control means is in the handle of the active electrode which enables the operator, without changing his position, to adjust the voltage to the optimum value at each point treated. Treatment consists, first, of exploring the bared region of distress with the moving active electrode to find the point of greatest sensitivity and, second, applying the impulses at and around the point for about one minute at a time for several minutes. Ordinarily treatments are given once daily on successive days.

The clinical results presently reported were obtained with pulse rates usually in the range of 8 to 10 per second. The voltages used depended upon the sensitivity of the areas treated, ranging from 100 to 300. Computed current intensities indicate peak values often in excess of one ampere. Because of the short duration of each impulse and the small number of pulses per second, the average current probably never exceeds one milliampere.

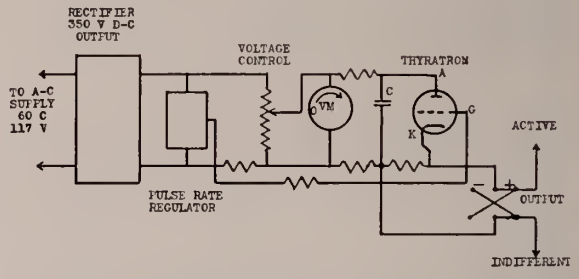


Fig. 1. — Simplified Schematic of Ultrafaradic Impulse Generator.

Courtesy of the Ultrafaradic Corporation

Results

Treatment in all cases of sprains, strains and charleyhorses gave complete relief. No return of symptoms was observed. No case was encountered in which there was lack of response to treatment. In almost every case a single treatment resulted in distinct alleviation and gave satisfactory

enough rehabilitation to allow the patient to resume full time activity immediately. Occasionally a patient was asked to return, and usually was treated, when it was later determined that the original treatment appeared to have been curative.

Table 1 summarizes the number of cases in each category with the number of treatments required for complete relief of distress in each case. It will be noted that sprains required an average of about 3 treatments, strains 2 and charleyhorses 1.5.

In 6 cases edema was grossly in evidence. Table 2 summarizes the decrease in swelling following a single treatment of five minutes' duration or less.



Fig. 2. — Photograph of the Ultrafaradic M-4 Impulse Generator.

Courtesy of the Ultrafaradic Corporation

Discussion

The significance of high peak currents is that only they reach deep-lying nerve and muscle fibers at liminal intensities in view of the spreading out of the currents in massive sections of the body. When these liminal currents flow through somatic lesions, no matter how deep, they incite referred pain and this, in turn, makes certain the finding of the optimum areas to be treated. A brief exploration with the active electrode of a relatively large area known to contain a lesion almost invariably discloses a small hypersensitive area standing out in sharp contrast with the sensitivity of the surrounding tissues. When treating these areas the practice is to adjust the voltage so that there is considerable referred pain, yet of no greater intensity than the patient is willing to tolerate. It should be said that inciting pain is not an object in itself; it is the necessary evidence that the desired stimulation and consequential mechanical stresses are induced in the fibers where the lesion is situated.

Table 1. — Analysis of Cases

Condition	Cases Treated	Treatments per Case	
SPRAINS			
Ankle	1	1	
Ankle	6	2	
Ankle	4	3	
Ankle	1	7	(1)
Ankle	1	7	(2)
Foot	1	2	
Foot with edema	1	2	
Knee with edema	1	3	
Shoulder with edema	1	3	
Wrist	1	1	(3)
Total	18	All cases 50	
STRAINS			
Back	3	2	
Arm and shoulder	1	4	
Ankle	3	1	
Gastrocnemius	1	2	(4)
Knee	1	2	
Sacroiliac	1	1	
Sacroiliac	1	2	
Sacroiliac	1	3	
Tenosynovitis, knee, traumatic	1	2	
Total	13	All cases 25	
CHARLEYHORSES (5)			
Arm muscle	1	1	
Thigh muscles	6	1	
Thigh muscles	5	2	
Thigh muscles	1	3	
Leg muscles	4	1	
Leg muscles	2	2	
Leg muscles	1	3	
Total	20	All Cases 31	

(1) The ankle was clinically well after 4 treatments. The patient returned three additional times because he "liked the treatments."

(2) The large number of treatments in this case should be considered multiple cases in an "accident prone" person. The patient was a large overweight woman who was relieved of her original symptoms by 3 treatments. Two days later she turned her ankle while running downstairs to answer the telephone. One treatment controlled this condition. Five days later the ankle became stiff and a tender spot appeared on the right instep caused by a tight shoe, requiring 3 treatments to control.

(3) The sprained wrist was severe enough to make writing impossible. It was relieved by the one treatment after failure of other methods of treatment over a period of five days.

(4) The strain of the gastrocnemius occurred during football scrimmage. It probably qualified as a charleyhorse, but was considered with strains because of excessive lameness and limping.

(5) Most of the cases of charleyhorse were treated within 24 hours of injury, but 1 case of nine days' duration required only 1 treatment on two successive days to obtain complete relief. No return of symptoms was reported in any case after discharge.

The stimulation of muscles and nerves by the reported means causes vigorous muscular twitching synchronized with the electrical pulsations. This form of muscular contraction serves as a kind of automassage, so that we have termed the action "deep massage" paralleling the term "deep heat" for diathermy. The average current from the impulse generator is too small to cause current resistance heating as in diathermy, but it is obvious that the vigorous working of the muscles by electric stimulation raises their temperature the same as natural exercise of comparable amount.

Table 2. — Summary of Decrease in Swelling Following a Single Treatment of Five Minutes Duration or Less

Condition	Circumference in Centimeters		
	Before Treatment	After Treatment	Contralateral Control
Sprained foot	22.5	21.7	20.5
Sprained ankle	32.2	29.5	27.2
Sprained ankle	27.5	24.5	24.5
Sprained knee	41.8	39.8	39.5
Sprained ankle	27.5	25.0	24.5
Sprained ankle	27.0	25.5	25.0

The relief of signs and symptoms of sprains and strains, while largely due directly to this automassage, may be indirectly influenced also by a reduction in swelling of the tissues. It is proposed that this decrease in swelling is due to the milking effect of muscular movement on the circulatory return from the areas primarily through the lymphatics. As we proceed with other studies, however, a vasomotor effect seems to be gaining in importance as a factor in the relief of edema. Also, there is enough evidence to suggest that the direct effect on other than vasomotor nerves plays some role in correcting the cause of discomfort, independently of the primary massage and the secondary circulatory effects.

Summary

Eighteen cases of sprain, 13 of strain and 20 of charleyhorse were treated with the Ultrafaradic M-4 Impulse Generator.® A general description of the impulse generator and its method of use is given. No case was encountered in which the lesion did not respond to treatment. No return of symptoms was observed. The sprains required an average of about 3 treatments, the strains 2 and the charleyhorses 1.5 for complete control. Satisfactory rehabilitation response was obtained with fewer treatments. Suggested mechanisms involved in treatment are: deep automassage stimulating circulation by a milking action; consequent decrease in the swelling of tissues; vasomotor stimulation, and a direct nervous effect other than vasomotor.

References

1. Ultrafaradic M-4 Impulse Generator, Council on Physical Medicine and Rehabilitation, J. A. M. A. 149:573 (June 7) 1952.

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ABSTRACTS OF MEDICAL ARTICLES

Renal Lithiasis: A New Concept Concerning Etiology, Prevention and Treatment. By Arthur J. Butt, M.D., Ernst A. Hauser, Ph.D., Joseph Seifter, M.D., and Joseph Q. Perry, M.D. South. M. J. 45:381-388 (May) 1952.

In presenting their concept of renal lithiasis in its various aspects, the authors state that because of certain colloids present, urine is a highly saturated solution and the protective action of urinary colloids is of major importance in preventing precipitation, agglomeration and conglomeration of crystalloids from a supersaturated solution. If the concentration of protective colloids is insufficient, stone formation begins or is accelerated. In a study of 680 subjects in West Florida, the incidence of stone was found to be almost inversely proportional to the degree of protective urinary colloids present.

Parenteral injection of hyaluronidase greatly increases the protective urinary colloids. The colloids are caused to set up a gel, thereby preventing electrolytes present from crystallizing. They act as excellent dispersing agents and prevent the formation of stone. It is reported that hyaluronidase therapy has been effective in preventing calculus formation or reformation over a period of nine to 12 months in 9 patients who had previously been rapid stone formers.

The role of protective urinary colloids in the etiology and prevention of renal lithiasis is here correlated with generally accepted factors important in calculus formation.

Patterns of Collateral Circulation in the Portal System Following Extrahepatic Inflammatory Processes. By Abbott Y. Wilcox, Jr., M.D., Edwin G. Bovill, M.D., and Renzo G. Olivetti, M.D. Gastroenterology 21:375-381 (July) 1952.

Two cases showing different patterns of collateral circulation in the portal system following extrahepatic inflammatory processes are presented. In both massive gastrointestinal hemorrhage occurred; in one, the obstruction manifested itself clinically by gastrointestinal bleeding and in the other, first by jaundice followed by delayed gastrointestinal bleeding.

Case 1 presented an unusual pattern, one not commonly demonstrated in extrahepatic portal obstruction, in which sodium morrhuate had been used as a sclerosing agent in treating the pancreatic fistula. Representing another pattern of collateral portal circulation, case 2 illustrates the extrahepatic portal obstruction produced by the fibrosing peripancreatitis involving the superior mesenteric vein as it passes beneath the pancreas.

It is of interest, the authors note, that in neither case was there clinical splenomegaly, that in case 1 altered liver profiles were not observed, and that in case 2 there were altered liver function tests which were suggestive of extrahepatic biliary obstruction.

The Use of Antabuse® in the Alcoholic Problem. By John J. McAndrew, M.D. South. M. J. 46:190-194 (Feb.) 1953.

Alcoholism is defined as a symptom of an underlying personality disorder rather than a disease, and antabuse® (tetraethylthiuram disulfide) is described as a drug which causes an excessive drinker to become sick instead of drunk. The pharmacologic properties and physiologic action of this drug are not fully understood. Physiologically it interferes with the normal metabolic breakdown of alcohol in the body, arresting oxidation of alcohol at the acetaldehyde level and thereby causing a remarkable rise in serum acetaldehyde. The clinical picture is that of acetaldehyde poisoning with phenomena of body flushing, cardiac palpitation, fall in blood pressure, headache, vomiting, dyspnea with hyperventilation and, finally, exhaustion and collapse.

Antabuse® therapy is designed to produce a certain amount of this clinical picture in conjunction with alcohol without endangering the patient's life if he should drink. This therapy is described, as are also both medical and psychiatric contraindications. The importance of psychiatric evaluation of the patient prior to administration of the drug is stressed. Antabuse® is regarded as an addition to rather than a substitute for any of the existing therapies in that in many cases it may make possible specific care for the underlying personality disorder. While it has its dangers, in the opinion of the author it is a safe drug when used at all judiciously.

Ligation of the Inferior Vena Cava. By Frederick H. Bowen, M.D., and (by invitation) George M. Stubbs, M.D. Tr. South. S. A. 63:79-85, 1952.

Four cases are reported in which ligation of the inferior vena cava was performed for various indications. The thrombophlebitis was idiopathic in 1 case, followed criminal abortion in 1 case, followed reformation of clot in 1 case of old postoperative thrombophlebitis, and in 1 case followed insertion of radium for carcinoma of the cervix. From their experience with these cases the authors believe that ligation of the inferior vena cava is indicated (1) when there is recurrence of emboli during or after an adequate course of anticoagulants (14 to 21 days of adequate prolongation of the clotting or prothrombin time), and (2) in cases in which there is a thrombosis of a tributary of the inferior vena cava above the superficial femoral vein causing emboli, and the use of anticoagulants is contraindicated (as in infected pulmonary emboli) or in the absence of adequate laboratory control of anticoagulants. They are of the opinion that this procedure is technically much easier to perform and more nearly insures protection against pulmonary emboli than does ligation of the superficial femoral veins of one or both legs and that fewer sequelae follow the caval ligation. Ligation of the inferior vena cava requires general anesthesia, however, and superficial femoral ligation can be done under local anesthesia.

The case of carcinoma of the cervix was followed for 10 months to fatal termination owing to extension of the carcinoma. A second case, in an 80 year old woman, came to autopsy after 18 months. The remaining cases were followed for six years and 21 months respectively. It was concluded that good postoperative care probably will prevent many of the undesirable postligation sequelae if this care is continued for the remainder of the patient's life.

Salmonellosis in Dogs. I. Bacteriological, Epidemiological and Clinical Considerations. By Mildred M. Galton, James E. Scatterday and Albert V. Hardy. J. Infect. Dis. 91:1-5 (July-Aug.) 1952.

Procedures used in the isolation of salmonella from dogs are described and the relative efficacy of the various laboratory procedures compared. Proteus organisms were observed as a prevalent contaminant in canine feces. Of 8,157 rectal swabs from dogs, 2,252 (27.6 per cent) were positive for salmonella. The proportion positive in different groups or communities ranged from very low to very high.

Fifty-three serologic types, including three new types, were encountered. Multiple types were found in 412 specimens. Salmonella types which were isolated frequently from dogs were also encountered in man. Evidence did not permit conclusions as to the significance of salmonella infections in dogs either as a source of spread to man or as a cause of disease in dogs.

Salmonellosis in Dogs. II. Prevalence and Distribution in Greyhounds in Florida. By Calvin L. Stucker, Mildred M. Galton, John Cowdery, and Albert V. Hardy. J. Infect. Dis. 91:6-11 (July-Aug.) 1952.

After describing the nature of the greyhound industry in Florida, the authors report a study in which all animals in kennels were examined by survey cultures. In Jacksonville, of 1,602 cultures, 697 (43.6 per cent) were positive with 878 isolations of salmonella; and in Miami, of 946 samples, 233 (24.6 per cent) were positive with 251 isolations. An additional 524 cultures were taken during a therapeutic trial on 44 dogs; 460 (87.8 per cent) were positive with 612 isolations. In all, 1,518 greyhounds were tested. There were 3,072 cultures, which yielded 1,390 positive specimens and 1,741 isolations of salmonella. The proportion of animals positive increased with the number of examinations, reaching 98 per cent in those cultured five or more times.

Annual minimal attack rates based on monthly cultural findings were in excess of 600 per 100 dogs per annum, or an infection every two months. Rates were higher in the fall and early winter. The cleaner kennels had lower rates, but the difference was not great.

Thirty-five types of salmonella were found, with multiple simultaneous infections detected more frequently than would be expected by chance alone. Therapeutic trials failed to reveal any significant modification of the infections by any of three antibiotics or sulfadiazine.

Salmonellosis in Dogs. III. Prevalence in Dogs in Veterinary Hospitals, Pounds and Boarding Kennels. By Hunter B. McElrath, Jr., Mildred M. Galton, and Albert V. Hardy. J. Infect. Dis. 91:12-14 (July-Aug.) 1952.

The bacteriologic findings on 3,459 specimens from dogs in 15 veterinary hospitals, 7 pounds and 4 boarding kennels in 8 different cities of Florida are presented. Of 2,438 specimens from hospitalized dogs, 525 (21.5 per cent) yielded salmonella, as did 71 (7.8 per cent) of 895 impounded dogs and 21 (16.6 per cent) of 126 animals in boarding kennels. There were 701 isolations of salmonella, representing 41 types from 618 positive specimens.

The proportion positive in different hospitals, pounds and boarding kennels varied markedly. Localized outbreaks were observed in several hospitals. Bacteriologic surveys of the environment in two hospitals yielded the same salmonella types as those previously found in the dogs from prepared food, utensils, fresh livers, a dust pan and the floor of an exercise pen.

Salmonellosis in Dogs. IV. Prevalence in Normal Dogs and Their Contacts. By Don C. Mackel, Mildred M. Galton, Herman Gray, and Albert V. Hardy. J. Infect. Dis. 91:15-18 (July-Aug.) 1952.

In this study, specimens for bacteriologic examination on normal family dogs were procured through community surveys, rabies immunization clinics and in veterinary hospitals (using dogs brought for immunization, bathing, boarding and surgical conditions). In all, 1,626 normal dogs were cultured; 244 (15.0 per cent) were positive for salmonella. The 41 types of salmonella encountered were widely distributed, but variations in prevalence were found. There was no secure evidence as to the epidemiologic significance to man of salmonella infections in the normal family dog.

Subtotal Cystectomy for Atonic Bladder. By Raymond J. Fitzpatrick, Louis M. Orr, Joseph C. Hayward and James B. Glanton. J. Urol. 68:206-213 (July) 1952.

These authors discuss the value of subtotal cystectomy in the treatment of large atonic bladders that fail to respond to all other therapeutic attempts. They add 2 cases of subtotal cystectomy in atonic bladders to the literature, reporting 1 case of myogenic bladder in a young woman and 1 of atonic bladder of neurogenic origin in a man, due to tabes dorsalis. They discuss the nerve supply of the bladder and the two types of bladder atony before offering theoretic discussion to enable one to evaluate critically the results of surgical intervention in such cases.

In summary, they observe that it is well to keep in mind, when planning a partial removal of the bladder for myogenic atony, that the hypogastric ganglia in the male are in close apposition to the seminal vesicles, rectum and inferior vesical and prostatic vessels. It is apparent, therefore, that operations about the lower portion of the abdomen and the perineum, particularly in an abdominoperineal resection, could result in injury to the hypogastric plexus and result in a neurogenic bladder. Similarly, in subtotal cystectomies the same careful consideration must be given to the neuroanatomic relationships, especially so in cases of myogenic atony since damage to the nerves could convert a myogenic atony into a much more serious neurogenic bladder.

The Address of the President. By H. Marshall Taylor, M.D. Ann. Otol., Rhin. & Laryng. 61:465-469 (June) 1952.

Presented before the American Laryngological Association at its seventy-third annual meeting in Toronto in May 1952, this address of the President is replete with subtle humor and wise philosophy. Observing that the earliest physician known by name today was a rhinologist, Dr. Taylor relates that Sekhet'enanch attended a Pharaoh of about 3500 B. C. Found in the King's tomb was a limestone slab on which were a drawing of the physician and an inscription stating, "He healed the King's nostrils." "Were we to speculate on the successful therapy employed by this early Egyptian rhinologist, how many of us," he asks, "would surmise that he advised the Pharaoh to discontinue the use of nose drops?"

Dr. Taylor extols the amazing accomplishments of modern science, particularly the phenomenal development of medical science. Like other sciences, he observes, the science of medicine has grown through the ages as a result of cumulative knowledge. But for Archimedes, Galileo, Roger Bacon, Newton and Descartes with their conspicuous achievements in the realm of synthetic thinking, Einstein would not have evolved his theory of relativity. Such acts of synthesis are essential to the upbuilding of the scientific process. Thinking along these lines some 2,000 years ago, Hippocrates, when asked "Who is the physician that is an honor to his profession?" replied:

> He who has merited the esteem and confidence of the public by profound knowledge, who has been led through the whole circle of sciences, who moreover neglects not to observe all the causes that may produce disorder in the animal economy.

Convinced, with Politzer, that the essence of medicine is summarized in the expression, "Everything is connected with everything," and that "a specialist should forage in every field of medical activity," Dr. Taylor encourages his confreres to be ever on the alert. Although the antibiotics have made less surgery necessary in some of the sinus and otitic infections, he finds his highly trained younger colleagues today not only well grounded in diseases of the ear, nose and throat but also versed in deep surgery of the neck, surgery of the salivary glands, bronchoesophagology, reconstructive surgery of the head and neck, allergy, audiology and physical medicine.

In addition to this broadened surgical field, he stresses the innumerable facets of the jewel of otolaryngologic research. He would mold the clay of professional knowledge and experience into contributions that will leave the world better off, for "it is ours to participate in the synthesis of medical thinking which today ventures to cross the threshold of a new era." Not unanswerable, the fascinating, stimulating questions which yet confound the wise men of otolaryngology give promise of glorious adventure. The Golden Age of Otolaryngology, he avers, lies ahead.

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Third—William C. Thomas, Jr., M.D...3-54..*Gainesville*
Fourth—Thomas C. Kenaston, M.D...4-55.....*Cocoa*
Fifth—Clyde O. Anderson, M.D...5-55...*St. Petersburg*
Sixth—Emmett E. Martin, M.D...6-54.....*Haines City*
Seventh—Erasmus B. Hardee, M.D...7-54....*Vero Beach*
Eighth—Russell B. Carson, M.D...8-55..*Ft. Lauderdale*

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(Terms expire Dec. 31, 1953)
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(Terms expire Dec. 31, 1954)
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(Terms expire Dec. 31, 1954)

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From Our President

As we enter into another year's activity of the Florida Medical Association, we again must meet the challenge of the changing times and new conditions, which may affect our position in the public eye. We must be ever on our guard to prevent the occurrence of incidents which will make us liable to criticism for failure to fulfil our duties and obligations as physicians. "Service above self" is the motto of one of our service organizations. It could well be adopted as the motto of our medical societies, and of individual physicians.

The intelligent use and application of what we now know to be the best available methods of diagnosis and treatment of disease are incumbent on each physician who holds himself out to be a physician and surgeon. There are, inevitably, grades of proficiency and variations in ability to apply intelligently what one has learned. This fact alone makes it necessary that we have complete confidence in our present system of medical practice, whereby certain physicians, with special knowledge and skill, will be available as consultants, in order that the latest and best methods of diagnosis and treatment will be made available to all.

Strict adherence to the ethical principles governing the activity of the consultant is mandatory. Any practices whereby the position of the attending physician or surgeon is prejudiced or supplanted by the consultant must be eliminated, in the best interest of medical practice. Avoidance of remarks calculated to reduce the prestige or status of the referring physician or surgeon must be a cardinal principle in these professional relations. The status of a medical or surgical consultant is an honorable one. Let us earnestly strive to maintain it.

A debt of gratitude is due the physicians in general practice who, by the very fact that they are engaged in general practice, are unable by reason of time alone to keep abreast of all of the advances being made in medicine, and who must necessarily turn to specialists for consultation and help in their practices. In the degree to which we render prompt and efficient service, either as attending physicians or consultants, we thereby advance the quality of medical service in our respective communities.

Frederick K. Herpel

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The Ambulance Hazard

Wailing sirens and careening ambulances, with threat to life and limb, seem to be an accepted feature of the American traffic scene. But need they be? Rather than condone this traffic hazard as a necessary evil, it might be well to take steps to correct it. In such an effort, the county medical society should have an important part.

Physicians, particularly in urban areas, will be interested in the investigation into the ambulance problem described in this issue of The Journal by Dr. L. L. Parks of the Florida State Board of Health. Under the title, "Are Speeding, Open Sirens and Red Light-Breaking by Ambulances Necessary?" Dr. Parks brings to light surprising statistics gathered in Miami and Jacksonville which led him to suggest remedial measures.

In a series of 808 ambulance cases studied at Jackson Memorial Hospital in Miami, only one third of the patients were hospitalized, and in only one eighth of the total number in the series was there believed to be justification for transporting the patients at maximum speed. In a study of 378 such cases at Duval Medical Center in Jacksonville, a few more than one fourth of the patients were hospitalized after their fast ride, and less than 5 per cent of the entire number could probably be properly regarded as emergencies. Too, observation in a smaller number of cases at this hospital revealed that the ambulance was speeding in the hospital block in over half of the cases, and in a like number, the shrieking siren screamed on to the very door.

In view of these figures, it is no wonder that Dr. Parks recommends that a committee from county medical societies decide what conditions should permit excessive speed and justify ambulances running through red lights. He also recommends that these societies urge cities to enforce proper ordinances regulating observance of traffic regulations by ambulance drivers which would not permit them to run through red lights nor travel at excessive speed except under specified conditions. His other recommendations, which would provide an educational program for ambulance companies, require Red Cross First Aid Certificates for ambulance drivers and create an efficient ambulance service system, also deserve careful consideration.

Dr. Parks is to be commended for this study, and the members of the county medical societies undoubtedly will not want to miss the opportunity to follow through on this investigation. Also to

be commended is Dr. C. B. Roesch of Jacksonville for his timely editorial entitled "The Big Noise," which appeared in the November 1952 issue of the Monthly Bulletin of the Duval County Medical Society and led Dr. Parks to make this investigation. They point the way to one means of accident prevention.

Heroic Work of Doctors Praised

While the tornado-minded South is hoping the hurricane season will not rival this spring's tornado season in activity, it never tires of hearing heroism recounted. Physicians working unceasingly for countless hours under exceedingly trying conditions to give aid to the injured and the dying certainly do not think of themselves as heroes and would be the first to disclaim the designation. Nevertheless, their colleagues across the nation and the general public are not deterred from acclaiming the local profession which rises nobly to an emergency, as in the disasters incident to recent tornadoes in Texas. Red Cross officials and others have been loud in their praise of the way the doctors acquitted themselves and hospitals cooperated in the major tornado emergencies of this season in two Texas cities, Waco and San Angelo.

In Waco, where more than 100 lost their lives and some 300 were injured, many severely, the offices of several physicians were completely destroyed. The office of one painfully injured doctor was so badly damaged by the tornado that it was bulldozed into the city dump as part of the rubble forming a mountain of debris.

Working throughout the night, setting up first aid stations, giving emergency treatment and administering plasma at the scene of the rescue efforts, Waco doctors also directed ambulances and worked long hours in the emergency rooms of the city's two hospitals. Many worked all night in the operating rooms. None sought the names of patients; none thought of remuneration for services rendered.

"The physicians," said Dr. Raymond F. Barnes, the medical director of the midwestern area of the American National Red Cross, "together with the bankers, merchants and other townspeople, gave everything in an all-out emergency effort to save lives and relieve pain.

"Three days after the tornado hit, the local medical society held a meeting in a staff room of one of the hospitals. A motion was passed unanimously that no physician of the Waco Medical Society would charge any tornado victim for medical treatment.

"Although I was not in San Angelo, I understand that the physicians there did an admirable job, too."

The doctor is schooled to meet emergencies. He expects to do so, would not have it otherwise, and would be the last to dramatize his role in disasters. Nevertheless, spectacular demonstrations strengthen doctor-patient relations and promote the profession in public favor.

Dade County Medical Association Celebrates Fiftieth Anniversary

Despite the calendar, age is relative. Half a century of existence finds some organizations in the full bloom of youthful vigor, with goals accomplished but a foretaste of achievements to come. The Dade County Medical Association is an excellent example. The Journal extends heartiest congratulations to this association, which on May 2, 1953 celebrated its Golden Anniversary.

On this gala occasion when some 550 of the 600 and more members of this largest component society of the Florida Medical Association gathered to enjoy a birthday party of special significance, they expended their well known talent for entertaining on themselves with great success. The many physicians of Florida and across the nation who have been recipients of their lavish hospitality will rejoice that these gracious and experienced hosts made merry among themselves in true Miami fashion. They were aided by their equally talented wives, who presented "Doctors' Wives on Review" as the comedy high light of the evening and otherwise assisted in making the celebration enjoyable.

A gracious gesture on the part of the Dade County Medical Auxiliary was a gift to the American Medical Education Foundation in the name of the Dade County Medical Association in the amount of one dollar for each of its 50 years. Presentation of this birthday token was made by Mrs. W. L. Fitzgerald, auxiliary president, to Dr. Ralph W. Jack, the association's president this anniversary year.

Passing in kaleidoscopic review across five decades, the milestones of progress made by this association make a pretentious showing. Not only has it kept pace with the phenomenal development of the Greater Miami Area, but it also has

maintained a high place in the forefront of the unprecedented advances in medical science during this history-making period. The six pioneer physicians who organized it on June 4, 1903 and its members who numbered only a score even 40 years ago would be astounded at today's flourishing association with its hundreds of members, trained in the many highly specialized branches of medicine, who individually and collectively fill with distinction its vital role in a great city and community which is a mecca for the nation.

One member offered this appropriate summary: "We have come far in our profession in Dade County. And there seems no limit to the future."

A Welcome Federal Government Philosophy

Physicians are apt to discount the day to day relationship between federal grants and their own medical practice. As a matter of fact, the ties are particularly close, so close that the doctor can ill afford not to keep abreast of the present changing trend in government. No one is more affected by the flow of federal dollars and the federal control accompanying them than the doctor, with the exception of the landlord and the grocer. Dealing as he does with state representatives, however, he usually does not recognize the regulatory hand reaching out from Washington.[1]

Federal funds, flowing out to the state under several programs, reach a staggering total well in excess of combined state and local spending in these fields. In all of them the medical profession is intimately involved. Watching over the spending of every federal dollar is some federal official, whose duties force upon the states a degree of federal control.

Old age assistance, or relief, is the largest category of personal concern to the doctor in his practice. Here physicians receive direct payments for medical care of the indigent. Next is aid to dependent children. Aid to the blind is a much smaller item, but here, too, doctors are deeply involved. Assistance to the permanently and totally disabled is the newest program. Doctors must determine disability originally and then continuously treat the disabled.

Objection to the growing regulatory pattern is receiving particular attention in the present Congress and is a problem confronting Mrs. Hobby and the new Department of Health, Education and Welfare. Senator Taft and other leaders desire to keep both money and responsibility closer to the people. They do not see the logic in collecting federal dollars from the states and then passing them back with instructions on how to use them.

Their proposal is that a commission be set up to study the whole problem of federal and state relations. The reason for the commission is that "the activity of the Federal Government has been extended into many fields which, under our constitutional system, are the primary interest and obligation of the several states and the subdivisions thereof." Its purpose is to study and investigate all the present activities in which federal aid is extended to state and local governments, and it is expected to determine and report whether or not there is justification for federal aid in the various fields. Not only health, education and welfare of all kinds but also housing, roads and many other fields will be covered.

"The general theory," said Senator Taft, "is to try to determine a philosophy of federal action in these fields in which, clearly, the primary obligation under our constitutional system rests on the state and local communities. . . . I hope we can develop that theory. I think that commission is supposed to take a year. By the time it reports, I hope we may get a definite philosophy that says where the federal government can go, where federal aid may be justified, what the conditions of it should be, and the general scope of federal activity which today has extended to a point where federal aid now costs the federal government alone about 1.5 billion dollars."[2]

How far and how fast this philosophy can be translated into legislative action is of course uncertain. The interworkings of state and federal health and welfare programs alone are both massive and complicated. Doubtless, however, Mrs. Hobby will at least be able to begin by making simple changes in some regulations in the sprawling octopus she has set out forthrightly to reorganize.

Progress in this effort should promise state officials a freer hand to use federal grants as they see fit. Physicians, in turn, will have fewer and fewer forms to make out, and fewer and fewer regulations to observe.

1. Washington Letter, Lady from Texas Promises a 'Few Changes' in FSA, Modern Medicine 21:56 (March 15) 1953.
2. Address of Hon. Robert A. Taft, J. A. M. A. 151:1201-1203 (April 4) 1953.

The Editor Invites Your Contributions on Data of Notable Interest

Florida Clinical Diabetes Association Organization Meeting Held

The first annual meeting of the Florida Clinical Diabetes Association was held at the Suwannee Hotel in St. Petersburg on May 14 and 15, 1953. Organization of the association was completed and the constitution and by-laws were adopted at a dinner meeting on May 14. Officers elected were: President, Dr. Fred Mathers, Orlando; Vice President, Dr. Sidney Davidson, Lake Worth; Secretary-Treasurer, Dr. Edward R. Smith, Jacksonville; Board of Governors, Dr. Richard H. Sinden, St. Petersburg; Dr. Carlos P. Lamar, Miami; Dr. George H. Garmany, Tallahassee; Dr. William P. Hixon, Pensacola; Dr. William W. Trice, Jr., Tampa; Dr. William P. Logan, Lakeland; Dr. William C. Thomas, Jr., Gainesville; Dr. Turner Z. Cason, Jacksonville; and Dr. Francis D. Pierce, Fort Lauderdale.

Orlando was chosen as the meeting place for the association next year, and it was decided that there would be a seminar on diabetes at the time of the meeting. When the board of governors meets in November, the program will be planned and it will be determined whether this meeting will be held in the spring or fall of 1954.

Speakers for the St. Petersburg meeting included Dr. Howard Root of the Joslin Clinic, Boston; Dr. F. G. Peck, Director, Medical Division of the Lilly Research Laboratories, Eli Lilly and Company, Indianapolis; and Drs. Lamar, Davidson and Smith. A special feature was a public night meeting at which the attendance was larger than at any previous meeting for the laity held in connection with a diabetes seminar. From the interest manifested, it appears that these meetings for the public constitute a high light of such occasions. Drs. Root, Peck and Smith were the speakers at this night meeting.

Report Polio as Paralytic or Nonparalytic

For the first time, the states are being asked by the United States Public Health Service to report cases of poliomyelitis as paralytic or nonparalytic. This system will serve as a guide to the Office of Defense Mobilization in allocating gamma globulin for polio this summer. In making this announcement, Dr. C. C. Dauer of the Office of Vital Statistics added that the ratio is about 60 paralytic to 40 nonparalytic cases.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Akerman, Joseph L., Apopka
Baker, Kenneth A., St. Petersburg
Boyd, Charles G., Fort Lauderdale
Crews, Marjorie A., Daytona Beach
Denser, Clarence H., Chattahoochee
Fessenden, Clarence L., Orlando
Fromang, Vernon L., Vero Beach
Futch, William D., St. Petersburg
Groom, Joseph J., Miami
Hattaway, Leonard F., Pensacola
Howarth, J. Cornall, Orlando
Lucas, Frederick H., Orlando
McClow, Marvin V., Jacksonville
Nathanson, Florence, Miami
Patton, William T., Pensacola
Payne, Walter C., Jr., Pensacola
Raper, George T., Clearwater
Ross, John B., Jacksonville
Seminario, Alfred P., Camp Chaffee, Ark.
Simpson, Loleta E., Orlando
Smith, William K., Clermont
Stitt, Richard M., St. Petersburg

DEATHS

Deaths — Members

Pracht, Henry W., Miami	May 13, 1953
Glick, Meyer J., Miami Beach	May 24, 1953
Hedrick, Donald W., Tampa	May 27, 1953
Murrow, Joseph S., Apalachicola	May 27, 1953

Deaths — Other Doctors

Arnold, Laurie J., Sr., Lake City	May 5, 1953
Staton, Torrence R., Atlanta, Ga.	May 7, 1953

1953 Medical District Meetings

"B", St. Augustine	October 19
"A", Tallahassee	October 20
"C", Tampa	October 21
"D," West Palm Beach	October 22

STATE NEWS ITEMS

Scientific Program for the 80th Annual Convention: Plans are now underway for the preparation of the Scientific Program for the 80th Annual Convention of the Florida Medical Association to be held at Hollywood, beginning April 25, 1954.

It is most desirable that the high quality of the previous programs be continued. In order to do this, your committee must have many papers and a wide range of subjects. It is, therefore, urged that you submit any proposed papers together with a brief resume of the subject to be discussed to the committee at an early date.

Applications must be received by early November, 1953 and should be mailed to Jere W. Annis, M.D., Chairman, Scientific Work Committee, Box 1021, Lakeland, Florida.

Specialty groups desiring their speakers on the state program must advise the Scientific Work Committee by November.

Dr. Allen E. Kuester of Cocoa has been named president of the Brevard County Tuberculosis and Health Association.

Dr. H. Clinton Davis of Miami entered the U. S. Army in May.

Dr. Cornelius A. Bird of Jacksonville spoke on the symptoms of cancer at a luncheon meeting of the Downtown Lions Club of that city recently.

Dr. Raymond H. King of Jacksonville has been elected first vice president of the Jacksonville Historical Society.

Dr. Thomas C. Frell of Hialeah entered military service on March 21 with the rank of captain (U. S. Army).

Dr. Leffie M. Carlton, Jr., of Tampa was reelected president of the Florida Tuberculosis and Health Association at the annual business meeting held recently in Jacksonville.

Four Florida doctors were awarded the honorary degree of Doctor of Science at the Centennial commencement exercises of the University of Florida on June 8, 1953. The recipients were Drs. William C. Thomas, Sr., of Gainesville, Walter C. Payne, Sr., of Pensacola, Turner Z. Cason of Jacksonville and Warren W. Quillian of Coral Gables. Dr. William Thomas Sanger, President of the Medical College of Virginia, who has given freely of his time to the University of Florida Medical Center, was the commencement speaker. Although not a physician, on this occasion he also received an honorary Doctor of Science degree.

Schedule of the 1953 Medical District Meetings has been announced by Dr. John D. Milton, Chairman of Council, as follows: "A," Tallahassee, October 20; "B," St. Augustine, October 19; "C," Tampa, October 21; and "D," West Palm Beach, October 22.

Dr. Louis M. Orr, II, of Orlando spoke on "Medicine at the Crossroads 1933-1953" at the Ninth Annual Meeting of the Conference of Presidents and Other Officers of State Medical Associations on May 31 at the Waldorf Astoria Hotel in New York City.

Dr. Orr was installed as president of the Conference at this meeting.

Dr. William J. Knauer, Jr., of Jacksonville entered the U. S. Army on November 17, 1952, with the rank of first lieutenant.

One hundred Florida newspapers carried 261 news items about the Seventy-Ninth Annual Meeting of the Association, April 26-29, in Hollywood. All daily newspapers, except four, printed at least one story; one North Florida daily carried 14. For the annual meeting in 1952, 187 items were printed; for the 1951 meeting, 184 were printed.

Dr. Harrison G. Palmer of St. Petersburg celebrated his fiftieth year in the practice of medicine on May 12.

Dr. Thaddeus M. Moseley, III, of Jacksonville spoke on the value of regular physical examinations as a means of cutting down the number of serious cancer cases at recent meetings of the Southside Business Men's Club and the Alpha Chi Omega Sorority.

Dr. Millard P. Quillian of Bradenton spoke on some of the problems faced by medical officers in combat zones during World War II at a recent meeting of the Bradenton Rotary Club.

Dr. Edward E. Cava of Miami entered the U. S. Air Force on May 24 with the rank of captain.

Dr. Charles A. Patterson of Pensacola spoke on cancer at a recent weekly meeting of the West Pensacola Civitan Club.

Dr. Cecil E. Miller of Sarasota was a recent guest speaker at a luncheon meeting of the Woman's Auxiliary to the Sarasota County Medical Society. His subject was the atomic bomb.

Dr. Edgar W. Stephens, Jr., of West Palm Beach spoke on the treatment and aid given crippled children by the Florida Crippled Children's Commission since 1930 at a recent meeting of the West Palm Beach Rotary Club. He was introduced by Dr. Theodore Norley, also of West Palm Beach.

Dr. Lawrence A. Toto of Miami Shores entered the U. S. Army on February 9 with the rank of captain.

Dr. Alphonsus M. McCarthy of Daytona Beach was chairman of the Daytona Beach Planning Committee for the Armed Forces' Day program on May 16.

Dr. Wesley W. Wilson of Tampa spoke on "Early Cancer About the Mouth" at the Fourteenth Annual Meeting of the Florida State Dental Assistants Association in St. Petersburg, April 19-21, 1953.

Dr. Frank A. Sica of Holly Hill spoke on "Insulin—Its Uses and Effects" at a recent meeting of the Licensed Practical Nurses' Association in Daytona Beach.

Dr. Thomas C. Maguire of Plant City was honored on May 13 with a giant public party in honor of his seventy-second birthday. More than 200 persons gathered at the Plant City Golf and Country Club for the celebration which started in the afternoon and ended with an old-fashioned picnic at 6 p.m. Dr. Maguire, who has practiced in Plant City since 1908, estimates that he has delivered between 3,000 and 4,000 babies in the Plant City area since he came here. Forty of his "babies" were among the crowd which paid him honor on his birthday.

The Florida Trudeau Society held its annual meeting at the George Washington Hotel, Jacksonville, May 14-15, 1953. Dr. Hawley H. Seiler of Tampa was elected president of the Society, and Dr. John G. Chesney of Miami was elected secretary.

Drs. Wray D. Storey and James N. Patterson of Tampa and Ira C. Evans of St. Petersburg took part in the scientific sessions at the recent annual meeting of the Florida Division, American Society of Medical Technologists in St. Petersburg.

Dr. J. Basil Hall of Eustis spoke on public health at a recent meeting of the Eustis Rotary Club.

Dr. Irwin S. Leinbach of St. Petersburg invested a Yugoslav surgeon-scientist, Prof. Dimitrije M. Juzbasic, with the hood of a fellow of the International College of Surgeons. The ceremony, which was held in Skopje, Yugoslavia, represents the first attempt to establish the International College of Surgeons in a Communist state.

Drs. Thomas M. Irwin and H. Marshall Taylor of Jacksonville attended the meetings of the Triological Society held in New Orleans in April.

Dr. Fred Mathers of Orlando has been elected president of the Florida Clinical Diabetes Association, and Dr. Sidney Davidson of Lake Worth has been elected president-elect.

Dr. Reuben B. Chrisman, Jr., of Miami took part in a program on socioeconomics at the Eighty-sixth Annual Meeting of the Texas Medical Association in Houston, April 26-29, 1953.

Dr. Grace C. Hardy of Jacksonville spoke on pediatric problems at the Riverside Presbyterian Church recently.

Dr. James G. Lyerly of Jacksonville attended the meetings of the Harvey Cushing Society in Hollywood recently.

Dr. Ralph W. Jack of Miami, who is vice president of the Continental Gynecologic Society, atetnded the annual meeting of the Society in Boston in May.

Dr. Ralph S. Sappenfield of Miami has been elected president-elect of the Southern Society of Anesthesiologists.

Dr. Gunnard J. Antell of Coral Gables was one of the speakers at a pre-school clinic sponsored recently by the Coral Gables Elementary School P.-T.A. All parents of pre-school children in the community were invited to attend.

Dr. George H. McSwain of Daytona Beach was guest speaker at a recent meeting of the Registered Nurses of District 6.

Dr. Fred I. Dorman, Jr., of Lakeland spoke on "The Physical Health of the Young Citizen, in Relation to His Character," at a meeting of the Lakeland Senior High School P.-T.A. in May.

Dr. Ashbel C. Williams of Jacksonville spoke on cancer at a recent meeting of the Kiwanis Club of Jacksonville.

Dr. Richard G. Skinner, Jr., of Jacksonville was recently elected chairman of the State Polio Planning Committee at its fifth annual meeting.

Dr. Joseph L. Selden, Jr., of Fort Myers spoke on cancer at a recent meeting of the members of District 7, Florida State Nurses' Association.

Dr. William J. Overman of Warrington spoke on "Psychological Aspects of Nursing," at a meeting of Florida State Nurses' Association, District 1, in May.

Dr. William H. McCullagh of Jacksonville spoke on mental and emotional illnesses at a recent meeting of the Exchange Club of that city.

Dr. H. Milton Rogers of Tampa is the new president of the Florida Heart Association. Dr. Alvin E. Murphy of Palm Beach was recently elected president-elect of the Association for the coming year; Dr. Milton S. Saslaw of Miami was elected vice president; and Dr. William P. Hixon of Pensacola is the secretary.

Drs. Lawrence H. Kingsbury and Harold W. Johnston of Orlando spoke on "Early Results in 150 Segmental Resections for Tuberculosis," at the meeting of the Florida Trudeau Society in Jacksonville in May.

Dr. Hawley H. Seiler of Tampa spoke on "The Indications for Segmental Resection and Local Excision in Pulmonary Disease," at the annual meeting of the Florida Trudeau Society in Jacksonville, May 14-15.

Dr. Nathan Weil of Jacksonville spoke on cancer before the April meeting of a Southside business men's group.

Dr. Eugene M. Frame of Jacksonville was in Philadelphia in May for the examinations of the American Board of Pediatrics.

Dr. Henry H. Graham, Gainesville, is scheduled as one of the principal speakers at the Annual State Senior Council of Home Demonstration Work to be held at the University of Florida the week of July 13. Dr. Graham will discuss overweight during a session on Wednesday afternoon, July 15. His address will be a part of the Florida Medical Association's Rural Educational Program. More than 500 farmers' wives from all parts of the state are expected to attend the Council.

Dr. Rothwell C. Polk of Jacksonville spoke on cancer before a recent meeting of the Woman's Missionary Society of the North Main Street Baptist Church.

Dr. N. Worth Gable of St. Petersburg and Mr. Stan Witwer, city editor of the St. Petersburg Times, instigators of the Medical Forum sponsored by the Pinellas County Medical Society and the Times, have returned from Greenville, S. C., where they helped set up a Forum series to be sponsored by the local medical society and newspaper.

Dr. Frank G. Slaughter of Jacksonville has returned from Savannah where he attended the world premiere of the motion picture based on his novel, "Sangaree."

Dr. Paul J. Coughlin of Tallahassee spoke on the "Visiting Nurse Program" at a recent dinner meeting of the Service League of Tallahassee.

Dr. William L. Musser of Winter Park has been elected second vice president of the Central Florida Association for Retarded Children.

Dr. Frank J. Pyle of Orlando spoke on "A Urologist's Ramblings" at a recent meeting of the Rotary Club of Sanford.

Dr. Clifford E. Vinson of Williston has been elected chairman of the Rural Health Committee of the Florida Academy of General Practice.

The staff of the annual Crippled Children's Clinic held in Starke recently included Drs. John F. Lovejoy, Bernard L. N. Morgan, and George I. Raybin of Jacksonville. Dr. Aubrey Y. Covington of Starke and all members of the Health Department staff assisted.

Dr. Lorenzo L. Parks of Jacksonville was principal speaker at a district conference on polio alertness sponsored by the National Foundation for Infantile Paralysis in Orlando recently.

The Editor Invites Your Contributions on

Data of Notable Interest

Dr. Leo M. Wachtel, Jr., of Jacksonville has returned to his practice after attending a fifteenth class reunion at Jefferson Medical College in Philadelphia.

Dr. Frank G. Slaughter of Jacksonville was the speaker at the commencement exercises of the Bartram School of that city.

Dr. E. Borland Gill, formerly of Fort Lauderdale, announces the opening of his offices in Leesburg.

Dr. Geoffrey H. Binneveld of Leesburg has completed his basic training at Fort Houston after being commissioned a captain (U. S. Army).

Dr. Thomas S. Adams of Hollywood has been elected to the Hollywood City Commission.

Dr. Turner Z. Cason of Jacksonville spoke at a luncheon meeting of the Downtown Lioness Auxiliary of that city in June.

Dr. Coy L. Lay of Lakeland spoke on cancer at a recent meeting of the Polk County Federation of Woman's Clubs in Haines City.

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COMPONENT SOCIETY NOTES

Dade

At the regular meeting of the Dade County Medical Association on June 2, Drs. Hunter B. Rogers and Louis Lemberg and the staff of the Jackson Memorial Hospital took part in "A Discussion of Pericarditis."

The Dade County Medical Association celebrated its fiftieth anniversary on May 2, 1953. The Golden Anniversary was celebrated with a "birthday party" for members and their wives. See more details about the Anniversary on page 42 of this issue.

Duval

The Duval County Medical Society's program on Radio Station WJAX, Jacksonville, was one year old the middle of May, according to announcement made by Dr. Ralph N. Greene, Jr., chairman of the Society's Committee on Public Relations. American Medical Association transcriptions furnished through the Florida Medical Association's Bureau of Public Relations are being used for the broadcasts. The program was begun under the supervision of Dr. Edward Canipelli, then chairman of the Public Relations Committee. It was continued by Dr. F. Gordon King who succeeded Dr. Canipelli.

At the regular meeting of the Society on June 2, Mayor Haydon Burns of Jacksonville gave a report on the atomic tests.

Escambia

The Escambia County Medical Society through the chairman of its Committee on Public Relations, Dr. Walter C. Payne, Sr., Pensacola, has announced plans for sponsoring the Florida Medical Association's fair exhibit at the Pensacola Interstate Fair, Oct. 19-25, 1953. Space has already been obtained, and blood pressure determinations and blood typing will be offered to the public without charge. This will be the fourth time the exhibit has been displayed.

Hillsborough

At the regular monthly meeting of the Hillsborough County Medical Association on June 2, Dr. Ned W. Holland of Tampa spoke on "The Cross Eyed Child."

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1953.

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1953.

Lake

The Lake County Medical Society held its monthly dinner meeting on May 6 at the Floridan Country Club.

Marion

Drs. John T. Stage and George M. Stubbs of Jacksonville were the guests of the Marion County Medical Society at their regular meeting on May 19. Dr. Stage gave a talk on anesthesiology, illustrated with lantern slides.

Nassau

The Nassau County Medical Society has paid 100 per cent of its state dues for 1953.

Palm Beach

The Palm Beach County Medical Society will sponsor a free medical forum each Tuesday evening during August at the First Presbyterian Church in West Palm Beach. Dr. Graham W. King, president, will be moderator. Members of the committee who will select the four topics to be discussed are Drs. Charles McD. Harris, Jr., of West Palm Beach, Charles A. Robinson of Delray Beach, David A. Newman of Palm Beach, Edward W. Wood of Lake Worth and Ernest C. Johnson, Jr., of Pahokee. Co-sponsors of the forum include the Palm Beach County Heart Association and Board of Health. The public will suggest topics to be discussed, and a question and answer period will be held after each program.

Pinellas

At the regular meeting of the Pinellas County Medical Society on June 1, Dr. Addison L. Messer of St. Petersburg spoke on "Prognosis in Bundle Branch Block."

Polk

The Polk County Medical Society is sponsoring a radio program, according to Dr. Ivan W. Gessler, Winter Haven, chairman of the Society's Committee on Public Relations.

OBITUARIES

Stewart Gordon Thompson

Dr. Stewart Gordon Thompson of Jacksonville died at Riverside Hospital in that city on April 23, 1953 after suffering a cerebral hemorrhage nine days previously. He was 71 years of age.

The son of the Reverend David Glen Thompson, a Presbyterian minister, and Ada Foster Thompson, Dr. Thompson was born in Oakdale, Ill., on May 27, 1881. He received his academic training at Geneva College, Beaver Falls, Pa., studied vital statistics and demography at Harvard University and in 1918 was awarded the degree of Doctor of Public Health by the Kansas City Medical University in Kansas City.

After serving in the auditing department of the Santa Fe Railroad for two years, Dr. Thompson from 1911 to 1918 held the office of Assistant State Registrar of the Kansas State Board of Health. So well did he fulfil the duties of this office that registration of births and deaths reached more than the 90 per cent requirement and Kansas was in consequence admitted to the United States Registration Area.

Leaving Kansas for Florida in 1918, Dr. Thompson came to Jacksonville to assume the post of Director of the Bureau of Vital Statistics of the Florida State Board of Health. He served in this capacity from 1918 to 1937, and under his leadership Florida attained the more than 90 per cent registration for births and deaths and was likewise admitted to the United States Registration Area. For nearly a decade, from 1918 to 1927, Dr. Thompson was collaborating epidemiologist of the United States Public Health Service assigned to duty in Florida, and from 1919 to 1937 was a special agent of the United States Bureau of the Census. For 15 years, from 1922 to 1937, he was the editor of Florida Health Notes.

A charter fellow of the American Public Health Association, Dr. Thompson was chairman of the Vital Statistics section in 1925 and again in 1926. He was the secretary of the Florida Public Health Association from 1930 to 1937 and in 1935 was president of the American Association of Registration Executives.

For more than 27 years Dr. Thompson served the Florida Medical Association officially. In January 1926 he became Business Manager, and from June 1937 until the time of his death he served in the dual capacity of Managing Director of the Association and Managing Editor of the Journal of the Florida Medical Association. His able leadership and profound influence are reflected in countless ways in the progress of the Association during the last quarter of a century. The high esteem in which he was held by the members has been attested anew in the many tributes received from the component county medical societies.

A resident of Jacksonville for 35 years, Dr. Thompson was a former Kiwanian and was a member of the Timuquana Country Club. He was a devout churchman and was an official member of the St. Johns Presbyterian Church. For 43 years he was a ruling elder in the Presbyterian Church.

In 1906, Dr. Thompson was married to Miss Florence A. Aikin of Bellefontaine, Ohio, who survives him. Also surviving are one daughter, Miss Joan A. Thompson of Atlanta; one sister, Mrs. Pearl T. Dodds of Pittsburgh; and one brother, Owen F. Thompson, D.D., a Presbyterian minister of Greeley, Colo.

Julius David Holly

Dr. Julius David Holly of Baltimore died on Oct. 9, 1952. He was 54 years of age.

Born in Baltimore on Jan. 26, 1898, Dr. Holly received his early education in the public schools of that city. He was graduated from the Baltimore City College, one of Baltimore's outstanding high schools, and later from the Mount Vernon College, where he had his premedical training before entering the University of Maryland. He was awarded the degree of Doctor of Medicine in 1921 by the University of Maryland School of Medicine and College of Physicians and Surgeons.

At the outset of his medical career, Dr. Holly planned to work in the field of anesthesia. He was a pioneer worker in certain phases of this branch of medicine and was particularly instrumental in the development of pentothal sodium. A brilliant scholar, he was associated with some of Baltimore's early anesthetists, including Dr. S. Griffith Davis.

In 1938 Dr. Holly came to Miami Beach. In his excellent work there as an anesthesiologist, he

(Continued on page 52)



1. *Dizziness . . . movement is within the head.*
2. *Objective vertigo . . . the environment is in motion.*
3. *Subjective vertigo . . . the patient himself moves in space.*



2



3

TYPES OF VERTIGO:

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The disagreeable sensations of dizziness which physicians are frequently required to explain to patients have been described by Simonton[1] as varying from a slight sensation of confusion to severe vertigo.

While dizziness or giddiness is classified as a sensation of unsteadiness with a feeling of movement within the head, in vertigo the environment seems to spin (objective vertigo) or the body to revolve in space (subjective vertigo). Labyrinthine disturbances are likely to cause a sensation of rotation. Among the more common causes of dizziness or vertigo, this author lists: Damage to the vestibular nuclei or tracts in the central nervous system, involvement of the vestibular end organs by disease of the ear, Ménière's disease, toxicity of drugs, ocular vertigo from sudden diplopia, visual field defects, looking down from heights and motion sickness due to hyperactive labyrinthine reaction from riding in vehicles.

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1. Simonton, K. M.: The Symptom of Dizziness, Arizona Med. *6*:28 (Sept.) 1949.

SEARLE *Research in the Service of Medicine*

(Continued from page 50)
distinguished himself principally in spinal anesthesia. He was a member of the Dade County Medical Association and of the Florida Medical Association for only a few years, but he won many friends and was revered for his professional accomplishments. His untimely death is deeply regretted by his Florida colleagues.

Frank James McKinley

Dr. Frank James McKinley of Tampa died at his home on Jan. 2, 1953 after a long illness. He was 75 years of age. Interment took place in Philadelphia, Miss.

Dr. McKinley was born in Columbia, S. C., in 1877 and was reared in Charleston, S. C. After serving in the Spanish American War, he received his medical training in Charleston and was graduated from the Medical College of the State of South Carolina in 1903.

In 1906 Dr. McKinley was licensed to practice medicine in Florida. General practice was his specialty. After 26 years of service as a physician to many Indian tribes, he was retired in 1941 from the United States Indian Service, Department of the Interior. He then was employed by the Collier Corporation at Everglades for five years. In 1947, ill health forced his retirement, and thereafter he made his home in Tampa.

Dr. McKinley was a member of the Sons of the American Revolution. He was also a Mason, a Shriner, and a member of the Blue Lodge at Philadelphia, Miss.

A member of the Hillsborough County Medical Association and the Florida Medical Association since 1944, he had held honorary status for the last two years. He was also a member of the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Marian McKinley, and one daughter, Mary Frances McKinley, both of Tampa; one son, Carlyle McKinley of Corpus Christi, Texas; a sister, Mrs. R. L. McGee of Tulsa, Okla., and two grandsons.

Ellis Welcome Holloway

Dr. Ellis Welcome Holloway died at his home in Tampa on Jan. 14, 1953. He was 71 years of age.

A native of Pavo, Ga., Dr. Holloway was educated in the public schools of Plant City. He received his medical degree from the Atlanta College of Physicians and Surgeons in 1911. That same year he entered the general practice of medicine in Tampa and continued to practice there for 42 years. Locally, he was a member of the Palm Avenue Baptist Church and the John Darling Lodge No. 154, F & AM.

Dr. Holloway was a member of the Hillsborough County Medical Association and for 36

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years held membership in the Florida Medical Association. He was also a member of the American Medical Association.

He is survived by his widow, Mrs. Helen Peterson Holloway, and one son, Charles Lester Holloway, both of Tampa; a brother, Ward Holloway of Plant City; two sisters, Mrs. J. R. McDonald and Mrs. Chris McDonald, both of Plant City, and three grandchildren.

Otho Winton Gardner

Dr. Otho Winton Gardner of Greensboro died in the Gadsden County Hospital at Quincy on Jan. 29, 1953. He was 78 years of age.

Born in Montezuma, Ga., on Dec. 11, 1874, Dr. Gardner received his medical education in Atlanta. In 1901 he was graduated from the Atlanta College of Physicians and Surgeons. Immediately thereafter he located in Greensboro, where he engaged in the general practice of medicine for 51 years.

In 1950 Dr. Gardner retired from the office of mayor of Greensboro after serving in that capacity since 1915. From 1925 to 1949 he was a member of the County Board of Public Instruction. He also served for many years on the Board of Stewards of the Greensboro Methodist Church.

On Dec. 11, 1951, the residents of Greensboro, along with many friends from over the state, honored Dr. Gardner for his 50 years of service to the community by celebrating "Doctor Gardner Day." On that day the Town Hall was dedicated to him.

Dr. Gardner was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, the Florida Medical Association and the Southern Medical Association. He was a fellow of the American Medical Association. Also, he was affiliated with the Gadsden County Hospital in Quincy.

Surviving are the widow, Mrs. O. W. Gardner; four daughters, Mrs. Eloise Featherstone and Mrs. Grace Cox of Miami, Mrs. Terry C. Lee of Tallahassee and Miss Christine Gardner of Greensboro; two brothers, Judge B. C. Gardner of Atlanta and J. D. Gardner of Camilla, Ga.; two sisters, Mrs. R. L. Green, Sr., and Mrs. Carl Green, Sr., of Greensboro, and five grandchildren.

Walter Galliber Miles

Dr. Walter Galliber Miles of Chattahoochee died Nov. 16, 1952. He was 51 years of age.

Born at Dalton, Ga., on Oct. 3, 1901, Dr. Miles was educated in his native state. He attended the University of Georgia, and in 1926 received the degree of Doctor of Medicine from the University of Georgia School of Medicine.

Upon completion of an internship at Children's Hospital in Augusta, Ga., he joined the staff of Florida State Hospital at Chattahoochee, where he remained for some six years. He then engaged in the private practice of medicine until 1936, when he returned to Florida State Hospital. From 1940 until the time of his death, he served as clinical director there. Throughout his entire medical career he was active in psychiatric affairs.

Dr. Miles was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association.

Surviving are the widow and two sons.

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From where I sit *by* Joe Marsh

PTA Gets Stung by a "Bee"

The local PTA is feeling sheepish today. Seems they complained the youngsters weren't learning enough. Said they couldn't even spell. So the kids challenged them to a spelling bee.

"I was captain of the PTA'ers," "Doc" Brown told me. "Both teams made the first round just fine. But on the second round Speedy Taylor went down on 'efficiency.' Then his boy Chip, who happened to be next on the school team, rattled it right off. From then on it was murder!"

So now "Doc" says that the whole PTA is thinking of signing up for night school!

From where I sit, it pays to look and think before you leap to conclusions. Take those folks who would deny me a glass of beer without a moment's thought. Or those who would tell me how to practice my profession. They wouldn't want me to interfere with their way of life. It's a good idea to think twice before you "spell out" rules for others.

Joe Marsh

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A Many Faceted Gem

Although the subject of Study Group was treated in one of its phases last month, it has so many facets it can be discussed again offering new perspective with each avenue of inquiry. It is the least monotonous of any of the chairmanships in the organization because it produces a source of interest according to inclination and needs of the group.

The first phase discussed, of course, was "knowing your organization." The League groups, Service, Welfare as well as the National handle this with dispatch by announcing a short but thorough course in Charter and By-Laws, as well as Parliamentary Law instruction which provisionals are expected to take as a first requirement to their future eligibility as responsible members in the organization. No one can be a good member of anything unless she knows to what she owes her allegiance and why, as well as how to participate.

It is all well and good to be eligible for membership in an organization because of one's husband's prestige and acceptability in his county society. But the drive, accomplishments and cohesion which make an Auxiliary outstanding will mature and strengthen appreciably when a doctor's wife is promoted from a provisional status, only when she has earned her own place in the organization. This can be accomplished through

individual effort to study and understand, not only the aims and nature of the Auxiliary, but the knowledge of the working procedure which is necessary to a smooth, just and harmonious meeting.

This procedure which should be the initial step of new members, either as individuals or as groups, would create pride and allegiance which a mere payment of dues cannot achieve.

To be organized is important, but organization is not an end in itself; it is a means to an end. Knowing why you are on your way evokes interest in how you travel. How you travel and charter your course reveals the type of person you are. The type of person you are determines how far you will go.

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BOOKS RECEIVED

It's YOUR Hospital and YOUR Life. By Lucy Freeman. Public Affairs Pamphlet No. 187. Pp. 32. Price, 25 cents (quantity prices available). Chicago, American Hospital Association, 1952.

This pamphlet presents a close-up view of hospitals, how they came to be, their current problems and their probable future development. Lucy Freeman, New York Times reporter specializing in news of welfare, psychiatry and social work, has drawn the picture realistically and perceptively in an effort to fill a long-felt need for a booklet which would portray the modern American hospital and set it down in its proper perspective in the community. She describes the complexity of operation and diversity of activities of today's hospital, the spiritual motivation of its interests and its steadily unfolding development. As pointed out by Dr. Anthony J. J. Rourke, President of the American Hospital Association, she leads the reader to appreciate that through his hospital he is able to reap the benefits of the amazing accomplishments of medical science and that it is these very accomplishments which have brought about the lengthened span of life in this country.

The booklet offers a helpful interpretation of the need for, the function of and the place of the hospital in community life. It may be ordered from the American Hospital Association, 18 Division St., Chicago 10.

The Literature on Streptomycin 1944-1952. By Selman A. Waksman. Ed. 2. Pp. 553. Price, $5.00. New Brunswick, N. J., Rutgers University Press, 1952.

Since publication of the first edition of "The Literature on Streptomycin" four years ago, references dealing with this antibiotic have increased from fewer than 1,200 to nearly 6,000. This new edition becomes of great importance, therefore, to the investigator of antibiotics, in general, and of streptomycin in particular. Furthermore, it is essential to make available to the medical profession the rapidly accumulating information on the numerous uses of streptomycin, alone or in combination with other drugs, in the treatment of various infectious diseases of man and animals. For the sake of completeness, other uses of streptomycin, as in animal feeding and in preservation of semen and viruses, have also been included.

The listing of the references and the arrangement of the author and subject indices follow the style in the first edition. A special effort has been made, however, to provide a more detailed subject index because the subject has become far more complicated since the appearance of the first edition.

In view of the rapidly accumulating literature on streptomycin, annual supplements, rather than new editions of this volume, are now planned. In addition, digests dealing with various uses of streptomycin will be published from time to time. The first of those contemplated has to do with clinical uses of streptomycin in diseases other than tuberculosis.



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Endocrine Treatment in General Practice. Edited by Max A. Goldzieher, M.D., and Joseph W. Goldzieher, M.D. Pp. 474. Price, $8.00. New York, Springer Publishing Company, Inc., 1953.

Endocrine treatment, as presented in this book, is an essential part of everyday medical practice. It encompasses all forms of therapy of the endocrinopathies as well as the use of hormones in the treatment of diseases and conditions regardless of the question of an existing endocrine deficiency. It enables the physician to take full advantage of the manifold and potent pharmacologic actions of all hormones, those long known and those newly developed such as ACTH and cortisone.

The book was written by 21 clinicians from many fields of medicine to meet directly the needs of the general practitioner for specific clinical guidance. Acting as consultants, the authors approach the problem of treatment as it is encountered in practice. Their starting point is the patient's history and symptoms, summed up in diagnosis, and this is followed by a thorough discussion of the most promising and practicable therapeutic regimen. The authors recommend the hormone preparations, doses, methods of application that have proved effective in their own practice. They state results to be expected, necessary cautions, and side effects of treatment to guard against.

The arrangement of the book is according to the localization of presenting symptoms and according to the types of metabolic disturbances. There is a detailed list of hormone preparations, and a complete index enhances the usefulness of the book. Inserted in the book is a booklet entitled Diet Prescription, which is a supplement to Chapter V: Carbohydrate and Fat Metabolism. The diet is worked out specifically for the diabetic patient, yet lends itself to easy and flexible prescription of any diet that is restricted in calories. Additional copies of the Diet Prescription may be ordered from the publishers, with or without the Diet Prescription Graph.

Clinical Obstetrics. By Members of the Staff of the Pennsylvania Hospital. Edited by Clifford B. Lull, M.D., and Robert A. Kimbrough, M.D. Pp. 732. Illus. 392 Price, $10.00. Philadelphia, J. B Lippincott Company, 1953.

Reflecting the teamwork of twenty key persons, each of whom contributes special knowledge and experience, this book comes from one of the oldest and most important teaching hospitals in America. It records the current methods of management of the pregnant woman in the Division of Obstetrics and Gynecology of the Pennsylvania Hospital. Since it is a record of practice, rather than an encyclopedia of obstetrics, it includes chiefly the material which the student and the practitioner require for rational care of the pregnant patient. The references are designed to be discriminating rather than exhaustive, and the many illustrations have been carefully selected for their teaching value.

Divided into nine sections, the material is organized for ready implementation into the practice of obstetrics. Every attempt is made to integrate the sciences toward sound clinical practice. The successive sections deal with anatomy, embryology and physiology; antenatal care and normal pregnancy with particular emphasis on prevention of complications; complications of pregnancy; normal labor; abnormal labor; operative obstetrics; the puerperium; the newborn, including the most recent data on hemolytic disease of the newborn; and a critical review of maternal and infant mortality over a 20 year period in the Pennsylvania Hospital, a summary of obstetric nursing practice, and a chapter on legal aspects of obstetric practice.

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References Cited

a. *J.A.M.A.*, Vol. 103, 1934, p. 318
b. *J.A.M.A.*, Vol. 135, 1947, p. 417

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MINERALS		VITAMINS	
*CALCIUM	1.12 Gm.	*ASCORBIC ACID	37 mg.
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COBALT	0.006 mg.	CHOLINE	200 mg.
*COPPER	0.7 mg.	FOLIC ACID	0.05 mg.
FLUORINE	3.0 mg.	*NIACIN	6.7 mg.
*IODINE	0.15 mg.	PANTOTHENIC ACID	3.0 mg.
*IRON	12 mg.	PYRIDOXINE	0.6 mg.
MAGNESIUM	120 mg.	*RIBOFLAVIN	2.0 mg.
MANGANESE	0.4 mg.	*THIAMINE	1.2 mg.
*PHOSPHORUS	940 mg.	*VITAMIN A	3200 I.U.
POTASSIUM	1300 mg.	VITAMIN B_{12}	0.005 mg.
SODIUM	560 mg.	*VITAMIN D	420 I.U.
ZINC	2.6 mg.		

*PROTEIN (biologically complete)	32 Gm.
*CARBOHYDRATE	65 Gm.
*LIPIDS	30 Gm.

*Nutrients for which daily dietary allowances are recommended by the National Research Council.

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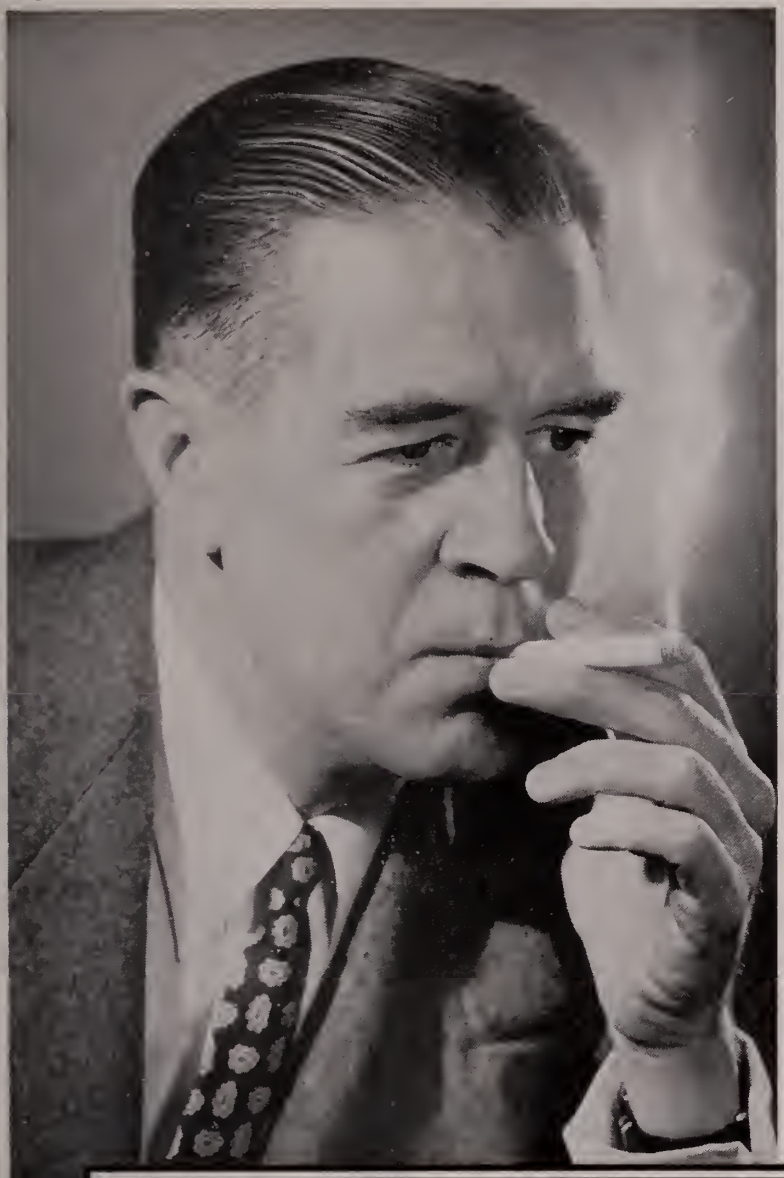
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1. Reich, W.J. et al. (1951), A Recent Advance in Estrogenic Therapy. I. Amer. J. Obst. & Gynec., 62:427, August. 2. Perloff, W. H. (1951), Treatment of the Menopause. II. Amer. J. Obst. & Gynec., 61:670, March. 3. Reich, W.J. et al. (1952), A Recent Advance in Estragenic Therapy. II. Amer. J. Obst. & Gynec., 64:174, July.

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Fort Lauderdale		521½ South Andrew Avenue	
Jacksonville		303 Clark Building	
Tampa		228 Cass Street Arcade Building	
Sarasota		237 Main Street, Room 15	
Fort Pierce		Florida Bank Building, Room 34	
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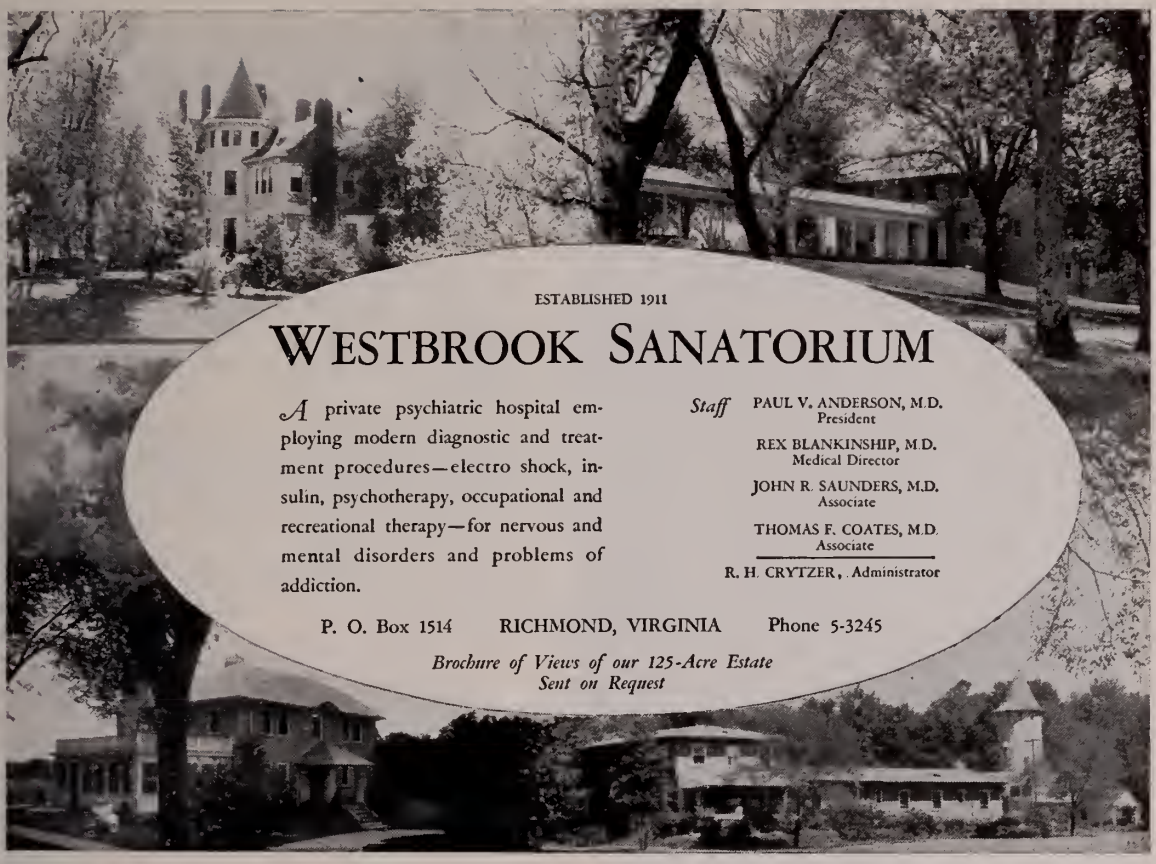
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
lorida Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
lorida Medical Districts	John D. Milton, Miami	Council Chairman	
A-Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, Oct. 20, '53
B-Northeast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, Oct. 19, '53
C-Southwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, Oct. 21, '53
D-Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, Oct. 22, '53
lorida Specialty Societies			
cademy of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
llergy Society	James H. Putman, Miami	Lewis Palay, Miami Beach	" "
nesthesiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
hapter, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
erm. and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
lealth Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
ndustrial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
eurology & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
b. and Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
phthal. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
rthopedic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Oct., '53
athologists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
ediatric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	
roctologic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	Hollywood, Apr. 25, '54
adiological Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
rological Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
lorida—			
Basic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 7, '53
Blood Banks, Association	Donald W. Smith, Miami	Mr. J. M. Potts, Miami	
Blue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
Blue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
Clinical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
Dental Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
Heart Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
Hospital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
Medical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	
Medical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Nurses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
Pharmaceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
Public Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, Oct. 22-24, '53
Trudeau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
Tuberculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	
Woman's Auxiliary	Mrs. Herschel G. Cole, Tampa	Mrs. Herbert B. Lott, Tampa	Hollywood, Apr. 25-27, '54
merican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
A.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
outhern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, Oct. 26-29, '53
labama Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
eorgia, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, 1954
. E. Hospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
outheastern Allergy Assn.	Walter Rucks, Memphis, Tenn	Kath. B. MacInnis, Columbia, S. C.	
outheastern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
outheastern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
ulf Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53



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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	20	
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	91	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	18	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	60	55	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D., Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	3	252
C	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	44	42	
	Duval *Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	259	227	
	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	28	25	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	12	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	25	23	
	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	28	26	B-4-55 Thomas C. Kenaston, M.D., Cocoa
	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	172	165	
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	75	693
D	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	176	169	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	20	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D., St. Petersburg
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	205	202	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	43	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	24	100%	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	93	615
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	8	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	123	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	16	15	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	97	95	
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	629	552	D-8-55 Russell B. Carson, M.D. Fort Lauderdale
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	12	888

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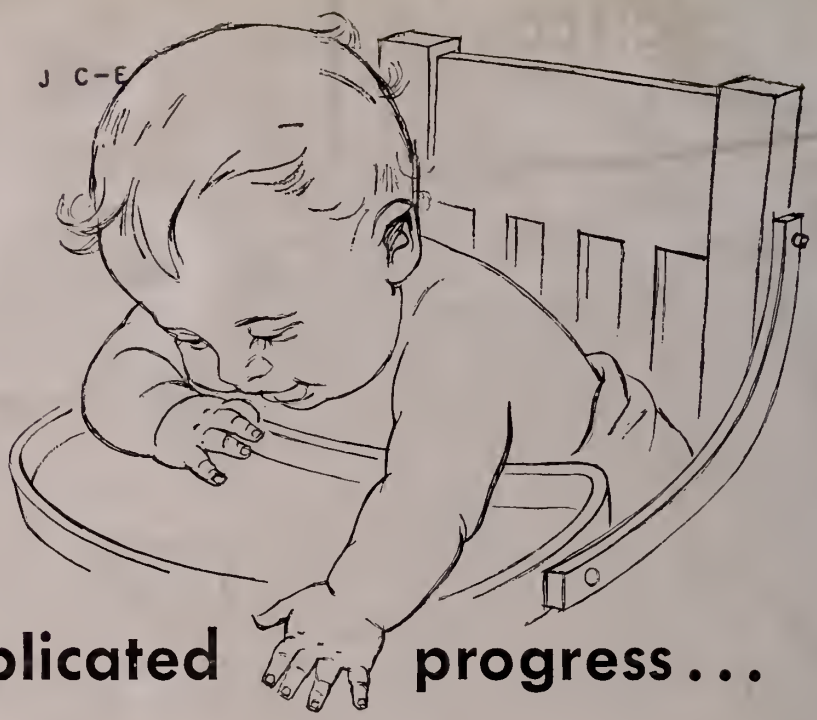
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uncomplicated progress...

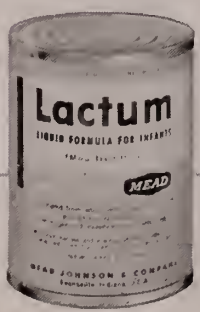
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It provides generous milk protein for sturdy growth and sound tissue structure, with sufficient calories to spare protein and meet the infant's energy needs.

Lactum is convenient and easy to prepare—simply mix equal parts of Lactum and water for a formula supplying 20 calories per fluid ounce.

1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592. 1951.



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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XL AUGUST, 1953 No. 2

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Harold Carron

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Guy A. Caldwell

Malformations of Thoracic Aorta
Jesse E. Edwards and H. Milton Rogers

Miliaria: Pathogenesis and Treatment
Isidore Pincus

OFFICIAL PUBLICATION OF THE
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relieves **hay fever** distress...



THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

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Volume XL AUGUST, 1953 No. 2

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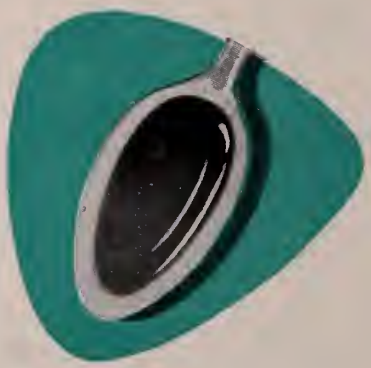
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When pollens provoke symptoms in sensitive patients, BENADRYL Hydroehloride (diphenhydramine hydrochloride, Parke-Davis) quiekly checks sneezing, nasal discharge, nasopharyngeal itehing, and laerimation. Beeause relief is rapidly obtained and gratifyingly prolonged, a comfortable "hay fever season" ean be preseribed for most patients.

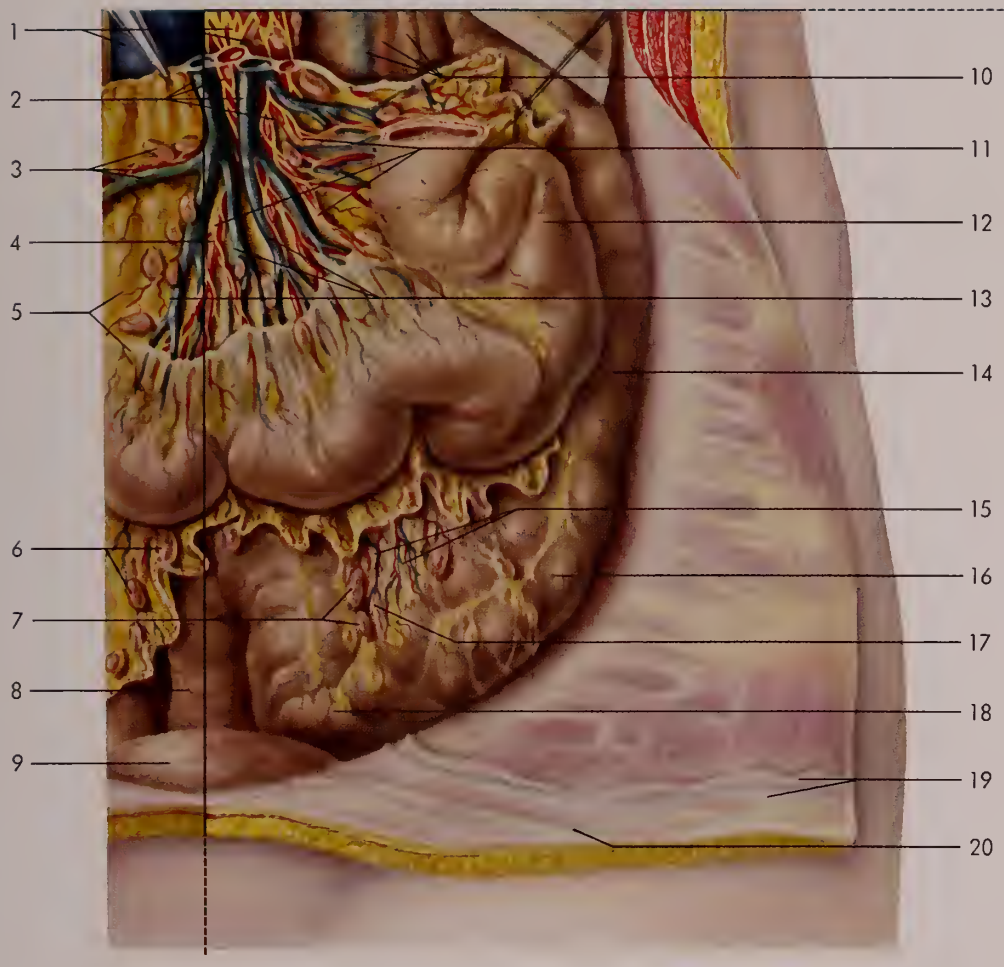
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Lower Left Quadrant of the Abdomen



1 Vena cava, aorta and abdominal aortic plexus

2 Branches of superior mesenteric artery and vein

3 Ileocolic lymph node and ileocolic artery and vein

4 Sympathetic abdominal plexus

5 Mesentery

6 Mesenteric lymph nodes

7 Mesocolic lymph nodes

8 Rectum

9 Urinary bladder

10 Inferior mesenteric vein, left colic artery and ureter

11 Intestinal arteries

12 Ileum

13 Intestinal veins

14 Descending colon

15 Branches of sigmoid artery and vein

16 Iliac colon

17 Mesocolon

18 Sigmoid colon

19 Epigastric artery and vein

20 Lateral umbilical ligament

This is one of a series of paintings for Lederle by Paul Peck, illustrating the anatomy of various organs and tissues of the body which are frequently attacked by infection, where aureomycin may prove useful.

Lederle

By providing broad-spectrum antibiotic action in all tissues and body fluids,

Aureomycin

HYDROCHLORIDE CRYSTALLINE

makes possible the rapid control of gastrointestinal and peritoneal infections.

For the prevention of infectious complications following abdominal surgery, it is unsurpassed.

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Tolserol Tabs. 0.5 gram

Disp. #100

Sig: One tablet 3 to 5 times a day. Take after meals or with 1/3 glass of milk.

Usually Inadequate

This prescription is typical of many written for Tolserol Tablets*, as seen in a recent prescription survey.

Although some patients will respond to such low dosage, much better results can be obtained by following the recommended dosage: 1 to 3 grams, 3 to 5 times per day.

In accordance with this recommendation, the first dosage schedule for a patient could be:

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Tolserol Tabs. 0.5 gram

Disp. #100

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Complete information on the use of Tolserol in muscle spasm of rheumatic disorders, neurologic disorders, and acute alcoholism is available from your Squibb Professional Service Representative.

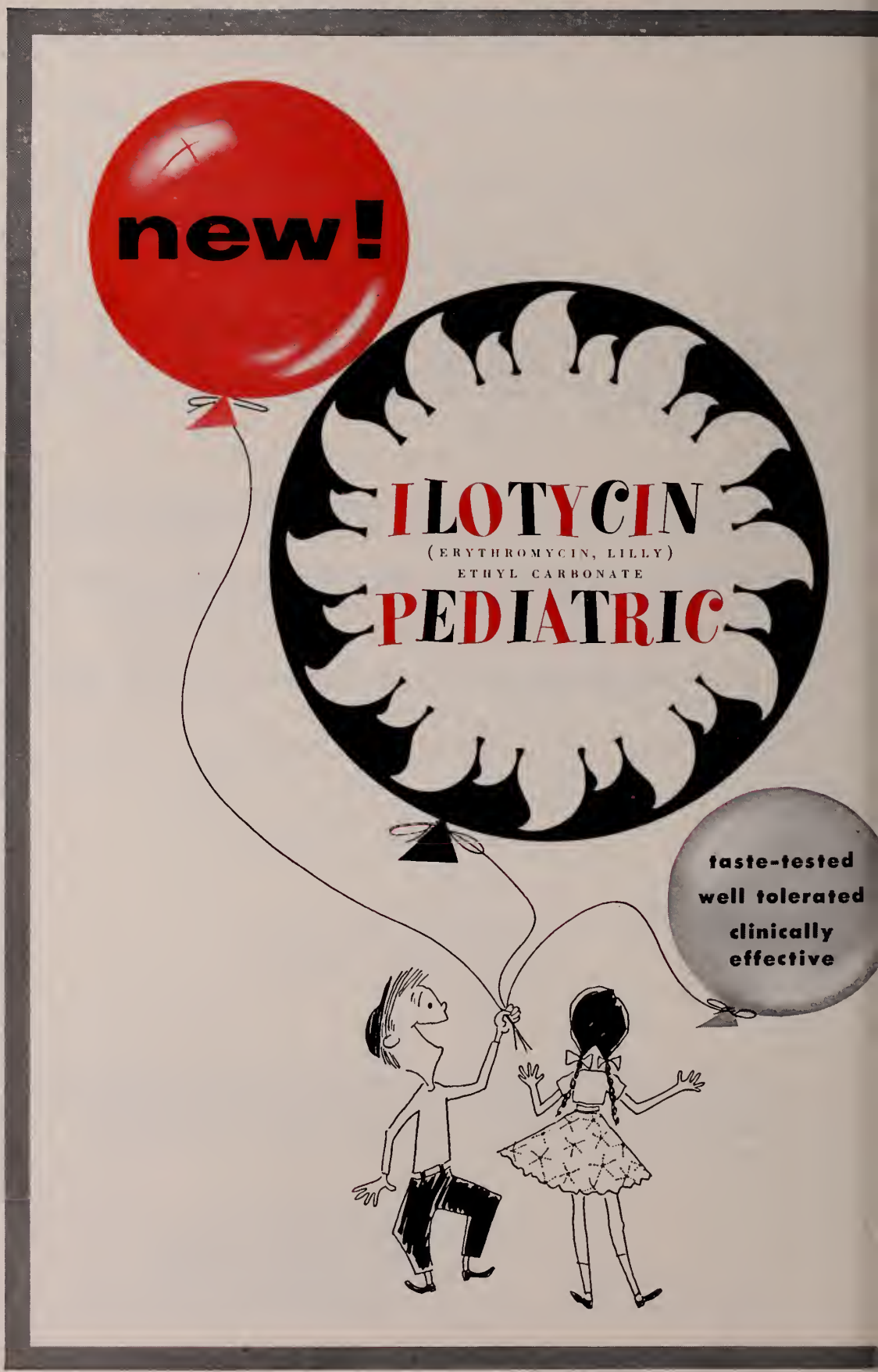
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L. H. Ashe, Manager
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new!
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PEDIATRIC
taste-tested
well tolerated
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For infections in children caused by staphylococci, streptococci, or both . . . the palatability, low allergenicity, and relative freedom from gastro-intestinal upsets make 'Ilotycin,' Pediatric, a prescription favorite. Youngsters (with an occasional incorrigible exception) take it without a struggle. "Tablet-shy" oldsters like it, too.

Lilly
THE ORIGINATOR
OF ERYTHROMYCIN

Formula:

Each 5 cc. (approximately one teaspoonful) contain 100 mg. 'Ilotycin' as the ethyl carbonate.

Dosage:

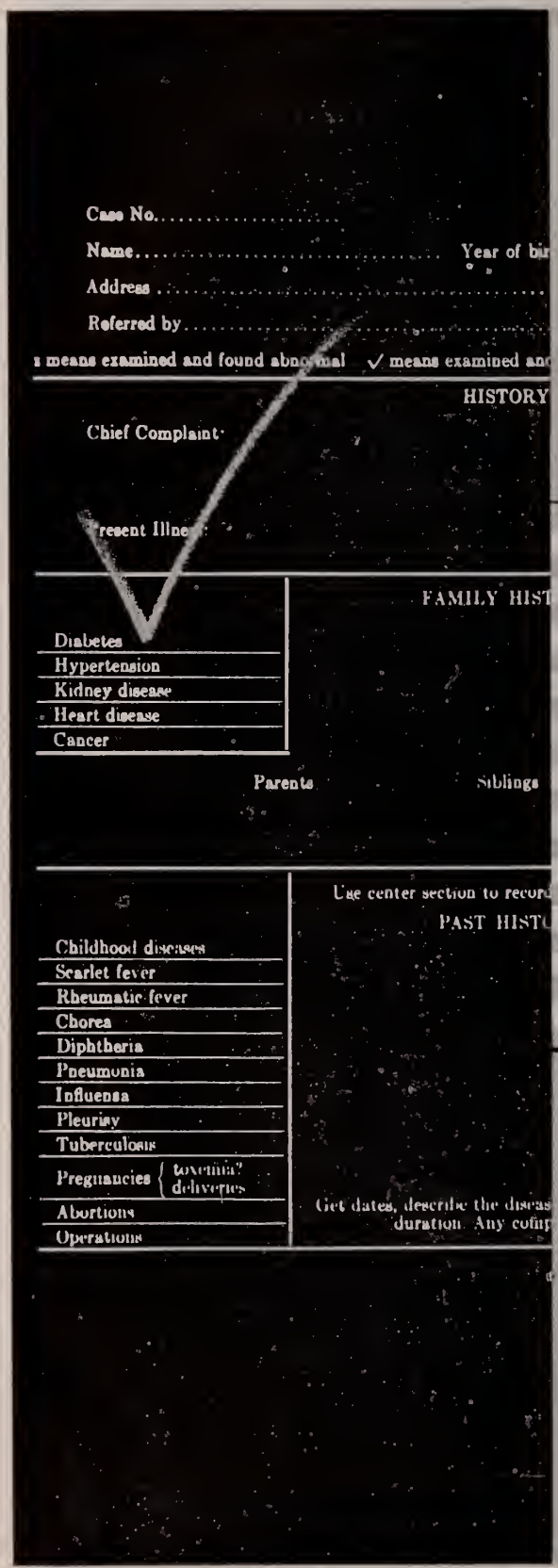
15 pounds—1/2 teaspoonful every six hours

30 pounds—1 teaspoonful every six hours

60 pounds—2 teaspoonfuls every six hours

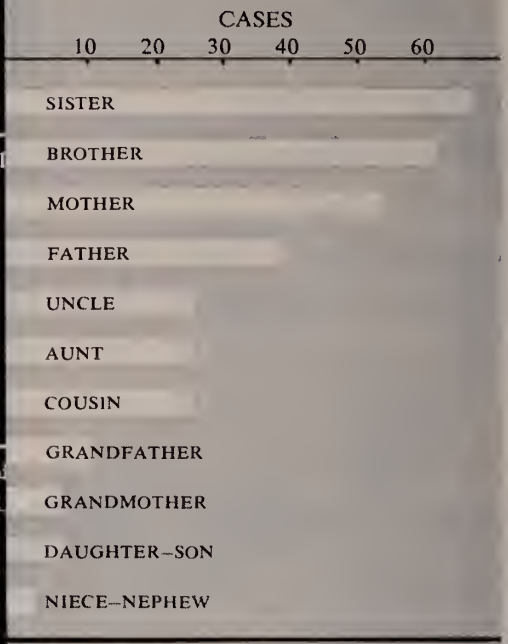
How Supplied:

Each package consists of one bottle containing 1.2 Gm. 'Ilotycin' as the ethyl carbonate in a dry, pleasantly flavored mixture; 45 cc. of water are added at the time of dispensing to provide 60 cc. of an oral suspension. After mixing, the suspension is stable for two weeks at room temperature.



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The Diabetic Relatives of 265 Diabetics[1]

In view of "...the very high incidence of...unsuspected cases among the blood relatives of diabetic patients,"[2] urine-sugar testing of all such individuals should be routine and frequent.

1. Barach, J. H.: Diabetes and Its Treatment, New York, Oxford University Press, 1949, p. 38.
2. Allen, F. M.: Diabetes Mellitus, in Piersol, G. M., and Bortz, E. L.: Cyclopedia of Medicine, Surgery, Specialties, Philadelphia, F. A. Davis Company, 1951, vol. 4, p. 505.

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"...particularly beneficial in the treatment of hay fever."[1]

Because CHLOR-*TRIMETON*® maleate, chlorprophenpyridamine maleate, has the greatest potency milligram for milligram of any available antihistamine, and because "Chlor-Trimeton has a relatively low incidence of side reactions,"[2] it is a drug of choice for hay fever patients.

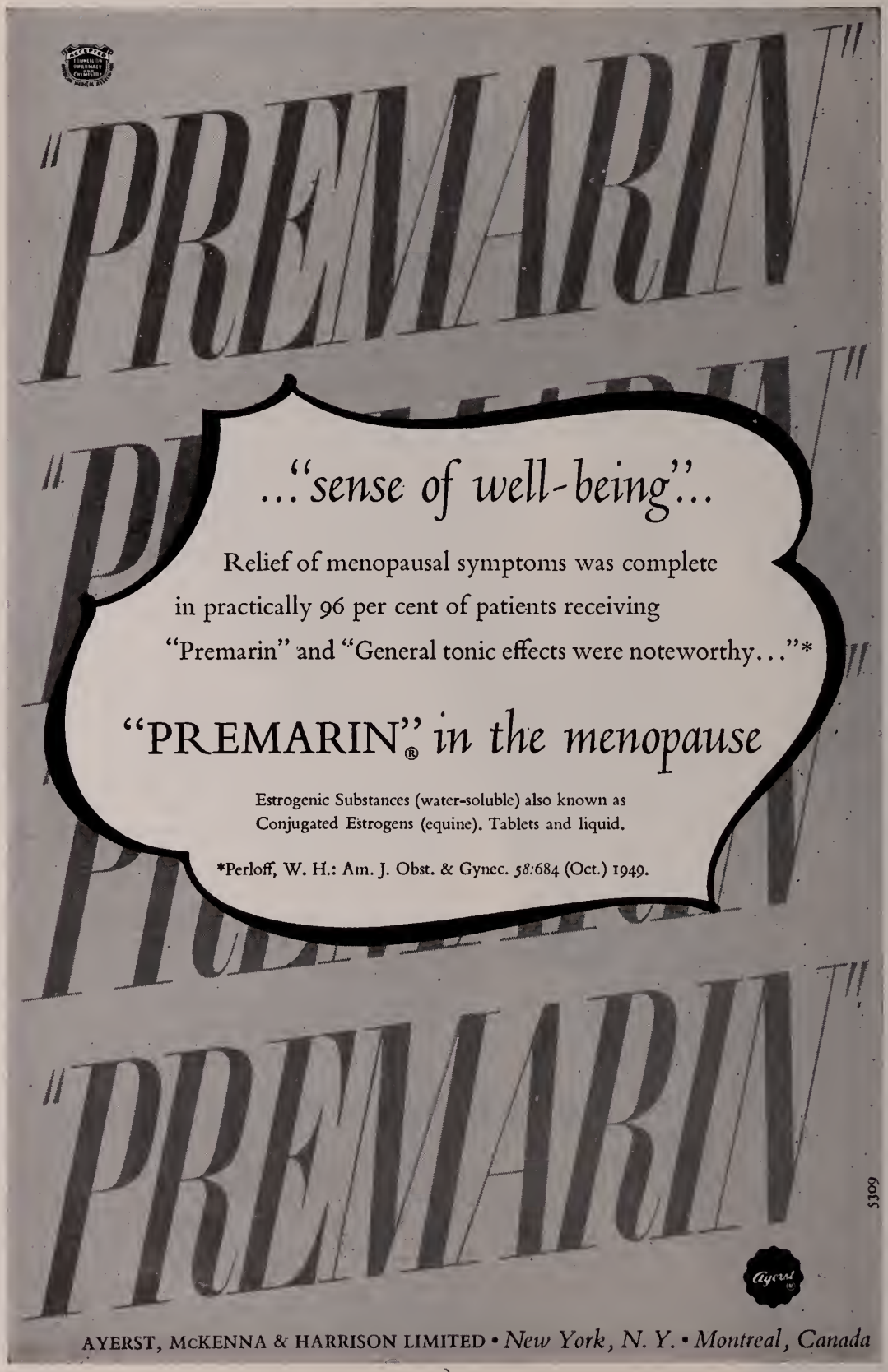
CHLOR-*TRIMETON*
maleate

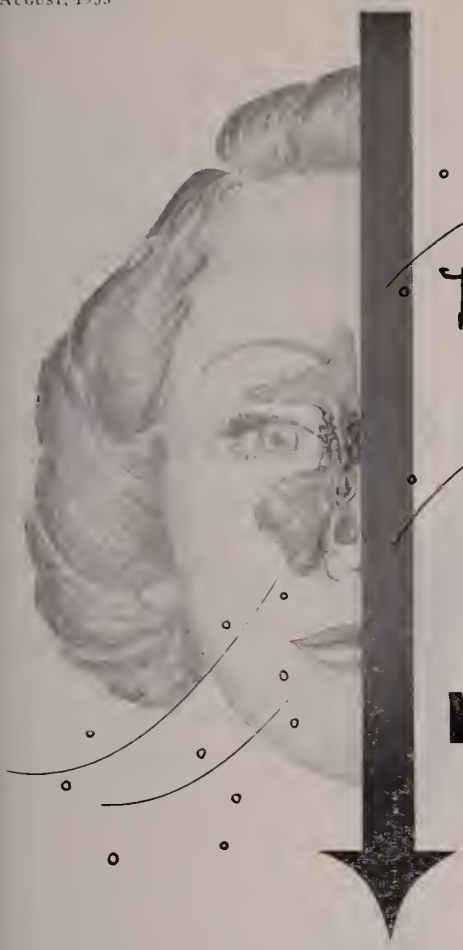
1. Silbert, N. E.: New England J. Med. 242:931, 1950.
2. Eisenstadt, W. S.: Journal Lancet 70:26. 1950.

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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
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To open congested air passages in hay fever

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HYDROCHLORIDE

. . . reduces nasal engorgement . . .

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A few drops of Neo-Synephrine 0.25% in each nostril will promptly check mucosal engorgement and hypersecretion, promoting greater breathing comfort over a period of several hours.

The resultant relief to the hay fever sufferer is decidedly gratifying. Prolonged action of Neo-Synephrine makes fewer applications necessary, consequently longer periods of rest and sleep are possible.

Neo-Synephrine does not lose its effectiveness on repeated application and may, therefore, be relied upon to give relief throughout the hay fever season.

Neo-Synephrine is practically free from sting and compensatory congestion; does not appreciably inhibit ciliary activity. Neo-Synephrine has been found relatively free from systemic side effects such as nervous excitation, cardiac reaction or insomnia even when tested on hypertensive, cardiac and hyperthyroid patients.[1]

Supplied in 0.25% solution (plain), bottles of 1 oz., 4 oz. and 16 oz.; 0.25% solution (aromatic), bottles of 1 oz. and 16 oz.; 0.5% solution, bottles of 1 oz.; 1% solution, bottles of 1 oz., 4 oz. and 16 oz.; 0.125 (⅛)% solution, bottles of ½ oz.; 0.5% water soluble jelly, in ⅝ oz. tubes.

1. Van Alyea, O. E., and Donnelly, Allen: *Arch. Otolaryng.*, 49:234, Feb., 1949.

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against staphylococci, streptococci and pneumococci —especially indicated when patients are allergic to penicillin and other antibiotics or when the organism is resistant.

A DRUG OF CHOICE

against staphylococci—because of the high incidence of staphylococcal resistance to other antibiotics.

A DRUG OF CHOICE

because it does not materially alter normal intestinal flora; gastrointestinal disturbances rare; no serious side effects reported.

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because the special acid-resistant coating developed by Abbott—and Abbott's built-in disintegrator—assure rapid dispersal and absorption in the upper intestinal tract.

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Announcing a scientifically in cigarette smoking...

KENT with the exclusive "MICRONITE" FILTER

DOCTORS have long been aware of the need for a really effective filter-tipped cigarette. P. Lorillard Company has been conscious of this problem, and after years of study, experiment and research believes it has developed a cigarette that meets the need.

It is the new KENT cigarette with the "Micronite"* Filter. Recent tests have shown that the Micronite Filter *approaches 7 times the efficiency of other filters in the removal of tars and nicotine* and is virtually twice as effective as the next most efficient cigarette.

All members of the medical profession will be interested in the facts about this new cigarette. To avoid possible confusion or misunderstanding by the general public, the details of the KENT studies given on these pages are for physicians only and will not appear in KENT advertising or promotion to the general public.

Micronite as a cigarette filter . . .

The new filter material—called Micronite—stems directly from the improved protective filters developed to meet critical air-purification problems in atomic energy plants.

When investigations showed that this filter medium was capable of removing all of the minute particles from a stream of cigarette smoke, the filter was modified for use in KENT cigarettes. *This was done in such a way as to permit the passage of pleasant aromatic smoke constituents, but with a removal of the more objectionable fractions of tobacco smoke to an extent never before accomplished.*

Efficacy of the Micronite Filter

The normal human subjects used in testing the Micronite Filter were divided into two categories—*susceptible and non-susceptible*—on the basis of their subjective reactions to cigarette smoking. Approximately two-thirds of the subjects *in this investigation* were *non-susceptible* while the remaining third were definitely *susceptible*. Other investigations have reported a somewhat similar ratio. (a)

To study the effects of this filter on physiological reactions to cigarette smoke, in both *susceptible and non-susceptible persons*, two different tests were employed, both being measurements of peripheral blood flow.

The first test involves the drop in skin temperature occurring at the finger tip, induced by smoking and measured according to *well-established procedures*. (b, c)

The second test is a measurement of vasoconstriction in the hand, as recorded plethysmographically. (d)

The results of these measurements—determined for Lorillard by an independent research organization—are shown on the four charts reproduced here. Concurrently, other outside independent laboratories are carrying on further research on the chemical and physiological effects of cigarette smoking *with new and original testing methods.*

From these charts, the following general conclusions may be drawn:

When cigarette smoke is drawn through a Micronite Filter, it is no longer capable of producing characteristic changes in peripheral blood flow in either *susceptible or non-susceptible persons.*

The Micronite Filter is vastly superior to *any other available filter now in use* for removing tars and nicotine in cigarette smoke.

Here are additional observations from work now in progress:

1. When smoke which has passed through a Micronite Filter contacts the conjunctival sac of the rabbit, far less irritation occurs than when the sac is exposed to the smoke from regular cigarettes or the smoke from popular filter-tipped brands.

2. Current studies also indicate that Micronite-filtered smoke is less irritating to mucous membranes

significant development

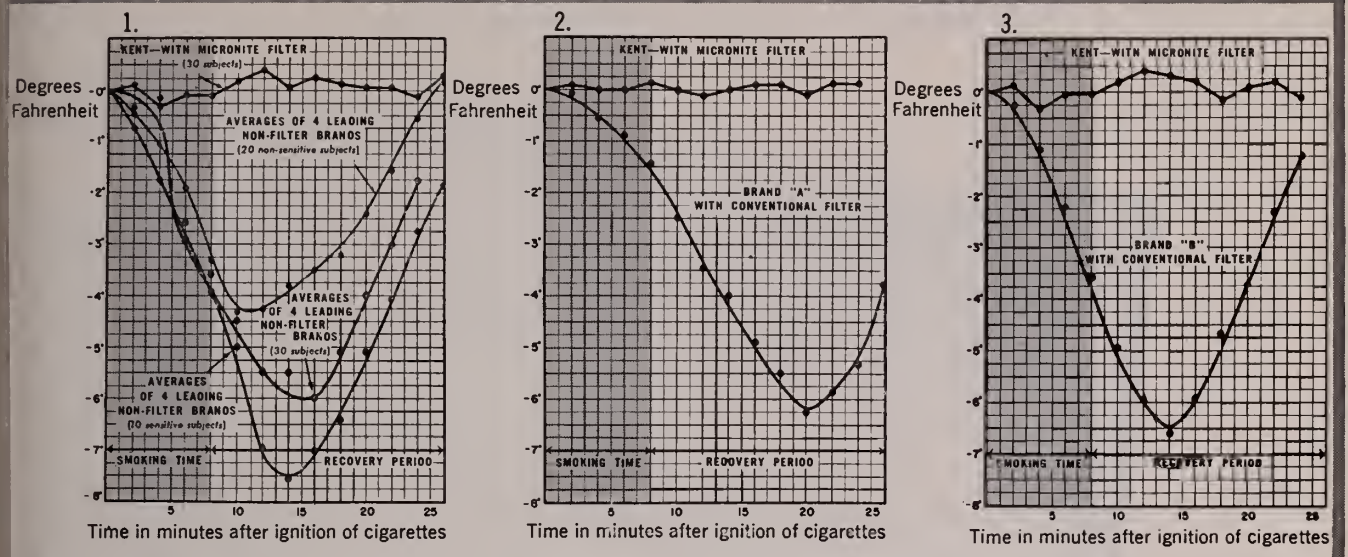
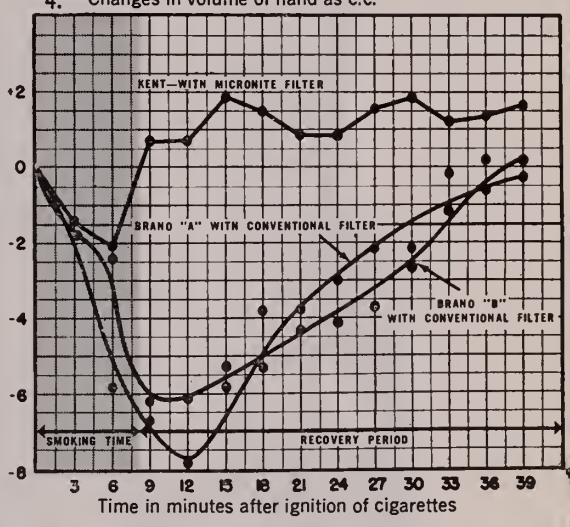


CHART 1. Comparison of KENT with leading non-filter brands. Effects on Peripheral Vascular System. Drop in surface skin temperature at the last phalanx induced by smoking one cigarette.

CHART 2. Comparison of KENT with Brand "A" conventional filter tip. Effects on Peripheral Vascular System. Drop in surface skin temperature at last phalanx induced by smoking one cigarette. Average for 15 susceptible subjects.

CHART 3. Comparison of KENT with Brand "B" conventional filter tip. Effects on Peripheral Vascular System. Drop in surface skin temperature at the last phalanx induced by smoking one cigarette. Average for 15 susceptible subjects.

CHART 4. Comparison of KENT with Brand "A" and "B" conventional filter tip. Peripheral vasoconstriction induced by smoking one cigarette. Peripheral blood flow as measured by continuous plethysmography on the hand. Average for 4 susceptible and 8 non-susceptible subjects.



than unfiltered smoke.

When the scientific evidence of the effectiveness of the Micronite Filter is compared *with* the effectiveness of other filters, *it shows that*—

The problem of smoker susceptibility to tobacco irritants may be largely overcome by KENTs. And for those people whose smoking should be restricted for therapeutic reasons, *KENTs should be considered* as the cigarette of choice.

References Cited

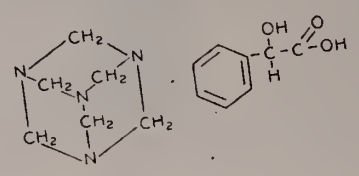
a. *A Manual of Pharmacology*, 7th edition, Philadelphia, W. B. Saunders Co., 1949, pp. 341-352.
b. *J.A.M.A.*, Vol. 103, 1934, p. 318.
c. *J.A.M.A.*, Vol. 135, 1947, p. 417.
d. *J.A.M.A.*, Vol. 104, 1935, p. 1963.



*PATENT APPLIED FOR

MANDELAMINE monograph in N.N.R.

METHENAMINE MANDELATE. — Mandelamine (NEPERA). — The salt obtained from the reaction of equimolecular amounts of methenamine-U.S.P. and mandelic acid-N.F. containing 48 per cent methenamine and 52 per cent mandelic acid by weight. The structural formula of methenamine mandelate may be represented as follows:



For tests and standards see Section B.

Actions and Uses.—Methenamine mandelate combines the actions of two established urinary antiseptics, methenamine and mandelic acid. The compound has the advantage that it acts to some extent as an acidifying agent, so that accessory medication to accomplish this is not ordinarily required as it is when either methenamine or mandelic acid is administered alone. However, in those infections caused by urea-splitting bacteria, preliminary acidification of the urine over a period of 24 to 36 hours prior to beginning therapy is essential to provide a urinary pH satisfactory for effective action of the compound. The combination also has the theoretic advantage that it is effective with smaller amounts of mandelic acid and may thus avoid the nausea and vomiting occasionally attributed to the use of mandelic acid alone.

Methenamine mandelate is useful as an adjunct for the treatment of pyelitis, pyelonephritis, cystitis, prostatitis, and infections accompanying a neurogenic bladder. It is effective against the following organisms commonly encountered in urinary tract infections: *Escherichia coli*, *Staphylococcus aureus*, *Staphylococcus albus* and certain streptococci. *Aerobacter aerogenes* and *Proteus vulgaris* are usually resistant, but not more so than to other commonly employed antibacterial agents. Comparative studies of the bacteriostatic and bactericidal action of methenamine mandelate indicate that its effectiveness is of approximately the same order as that of the sulfonamide drugs or of streptomycin. It is sometimes effective when drug resistance to other agents occurs with certain otherwise susceptible bacterial strains.

Methenamine mandelate is seldom associated with untoward effects; in therapeutically effective amounts, gastric disturbance is infrequent and other toxic manifestations are relatively rare. It is contraindicated in the presence of renal insufficiency.

Dosage.—Methenamine mandelate is administered orally. Average adult dose: 0.75 to 1.0 Gm. three times daily. For children over 5 years of age, 0.25 Gm. three times daily; infants less than 1 year of age, 0.25 Gm. twice daily.

NEPERA CHEMICAL COMPANY, INC.

Tablets Mandelamine: 0.25 Gm. enteric coated.

U. S. patent 2,124,321. U. S. trademark 347,322.

Upjohn

long-acting
androgen:

Depo-Testosterone

Trademark Reg. U.S. Pat. Off.

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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

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Testosterone Cyclopentylpropionate .....50 mg. or 100 mg.
Chlorobutanol ..... 5 mg.
Cottonseed Oil .....q.s.

50 mg. per cc. available in 10 cc. vials

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The Upjohn Company, Kalamazoo, Michigan



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ALLERGIES...

transform discomfort
into well-being



Such a transformation initiated by Neo-Antergan enables many allergy patients to live comfortably through difficult Summer months when pollen levels soar.

By effectively blocking histamine receptors, Neo-Antergan brings significant symptomatic relief with a minimum of undesirable physiologic effects.

Promoted exclusively to the profession, Neo-Antergan is available only on your prescription.

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Neo-Antergan®

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(PYRILAMINE MALEATE)

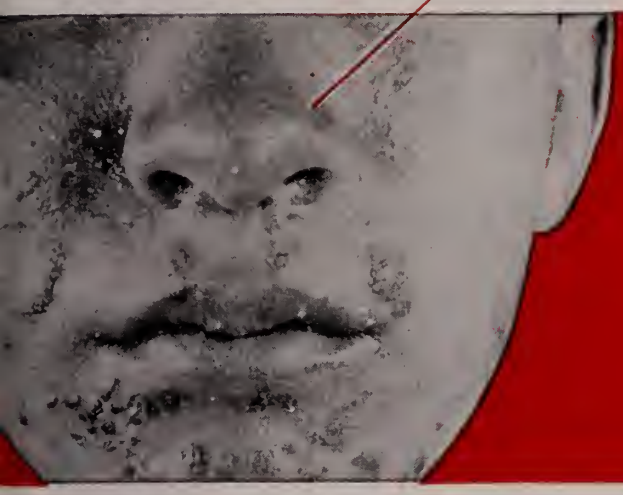
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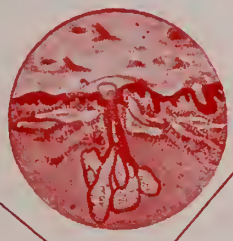
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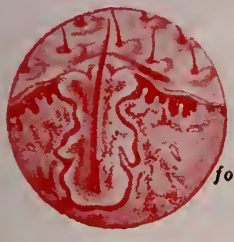


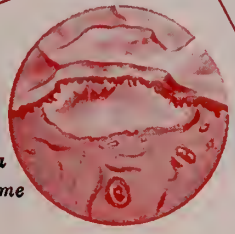


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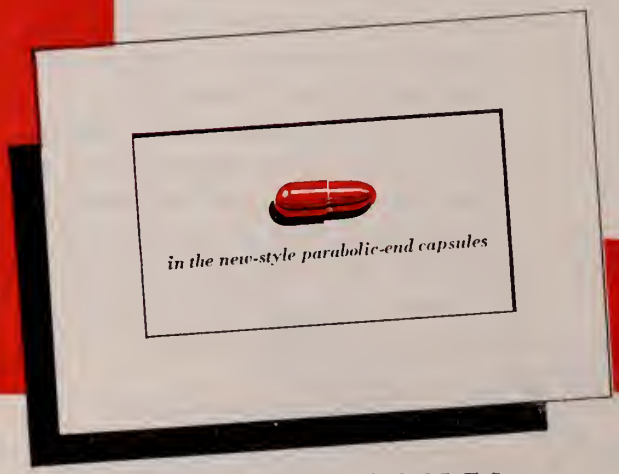
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Prevention and Treatment of Anesthetic Accidents

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TAMPA

Anesthetic accidents and complications are the major hazards in surgery today. Few fatalities occur as a direct result of surgical trauma, but a carelessly administered anesthetic can turn a surgical triumph into a veritable catastrophe. Most anesthetic accidents occur as a consequence of poor patient preparation, improper premedication, poor choice of anesthetic agent or technic, or careless administration of the anesthetic. For the sake of convenience, one may classify anesthetic accidents according to the sites of insult, remembering, however, that often the fatal complication will occur as a result of trauma at a distant site. The main groups encompassing these anesthetic difficulties are in order of their frequency of occurrence (1) respiratory, (2) circulatory, (3) cerebral, and (4) peripheral. In addition, there are those accidents occurring while the anesthetic is being given but not necessarily related to its administration.

Respiratory Accidents

In the first group, the respiratory accidents, there are those related to poor patient preparation. This situation most frequently exists in acute intra-abdominal catastrophies such as a ruptured viscus or acute intestinal obstruction. In these emergency cases, the patients are in a state of impending shock. There is fluid imbalance with a loss of electrolytes and fluid into the intestine or peritoneal cavity. Upon the induction of anesthesia, there occurs a relaxation of the pharyngeal and gastric sphincters with a consequent reflux regurgitation of gastric and intestinal contents into the pharynx. Aspiration of vomitus and laryngospasm occur with subsequent frequently fatal results. Abdominal distention of any degree interferes with adequate respirations, particularly if the patient is placed in the Trendelenburg position. Gastric or intestinal suction should be employed in all such cases, and intravenous fluids, plasma, or blood should be administered until the pulse rate falls below 100 and the blood pressure reaches a stable level. Narcotics administered to patients in shock or impending shock should be given intravenously, since a deficient circulation will not pick up hypodermic medication until the shock is corrected. Only after these conditions have been satisfied is it safe to proceed with the administration of an anesthetic. It is never safe, regardless of the desirability of the obtained relaxation, to administer a spinal anesthetic to a patient with either intestinal obstruction or a ruptured viscus, for it is the sympathetic system alone in these patients that is maintaining the circulation. Administration of a spinal anesthetic removes that last constrictor influence on the peripheral vascular system, and irreversible shock usually results.

Proper premedication of the surgical patient includes the use of a narcotic to decrease metabolic activity, provide sedation, and decrease the amount of anesthetic required. A belladonna derivative, preferably scopolamine over atropine, should be given to obtund vagal reflexes, provide psychic sedation, decrease secretions, and furnish amnesia for the visit to the operating theater. Preferably, these drugs are given one to one and one-half hours prior to the time of the scheduled operation, for the narcotics reach their peak of efficiency in that time when administered hypodermically. If time does not permit of this interval, the premedication should be given intravenously, following which maximum effect will be

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obtained in 10 minutes. Premedication given "on call to the operating room," or while the patient is on the stretcher on the way to the operating room frequently results in excessive salivation with pulmonary aspiration during anesthetic induction. Induction of anesthesia is delayed by struggling of the unsedated patient. Apnea frequently results when the maximum effect of the anesthetic coincides with the maximum depressant effect of the premedication in the middle or at the termination of the operative procedure. Hiccups may result, particularly during induction with the intravenous barbiturates, if the vagal reflexes are not obtunded by the use of belladonna derivatives preoperatively.

By far the greatest number of anesthetic difficulties occur during the administration of the anesthetic and particularly during the induction period. How frequently have you heard that dreaded laryngeal stridor of laryngospasm occurring with an intravenous barbiturate induction, looking down to see a cyanotic patient making violent respiratory efforts but moving no air? Laryngospasm occurs most frequently when there is pharyngeal or laryngeal stimulation due to an irritant concentration of anesthetic gases or vapors or too early introduction of an airway. It may occur with premature stimulation of the patient after the intravenous administration of the barbiturates. Laryngospasm will invariably occur with the use of the intravenous barbiturates when there is dilatation of the anus, dilatation of the vagina, periosteal stripping of a rib, or any manipulation about the neck. Intravenous barbiturates should never be used for anesthesia about the head, neck, nose or throat for fear of fatal laryngospasm unless there is an endotracheal tube in place. It is far safer and much easier on both the patient's and surgeon's coronaries to use ether insufflation anesthesia for head, neck, and oral surgery when the facilities for endotracheal intubation are not at hand.

When laryngospasm does occur, its first treatment consists of positive pressure oxygen with an anesthetic bag and mask. Intermittent positive pressure on the rebreathing bag with oxygen alone will break up the laryngospasm in most cases. When this method fails, the intravenous use of curariform drugs is recommended. When it then becomes possible to force oxygen through the spasming larynx, intermittent positive pressure should be continued until the curariform drug is metabolized. If all such measures fail, and definitely before the circulation begins to fail, an endotracheal tube should be inserted, or a tracheotomy should be performed.

Pulmonary edema occurring during the period of anesthesia is usually the result of the patient breathing against obstruction of the airway. Noisy respiration, while it informs the anesthetist of continued respiratory effort on the part of the patient, is of necessity obstructed respiration. Obstructed respiration leads to inadequate respiratory exchange with its attendant deficient oxygenation, increased carbon dioxide retention, and subsequent development of pulmonary edema. The anesthetized patient has a labile vascular system, reacting unfavorably to changes in position and particularly to the overadministration of intravenous fluids. Pulmonary edema may result from overloading of the right side of the heart with intravenous fluids, and their administration should be judicious even in a healthy patient. When given intravenously to the average patient, 500 cc. per hour can be handled without difficulty. The hypertensive patient or the one with borderline compensation can handle much less. When pulmonary edema occurs, all intravenous fluids should be stopped, the patient should be placed in the reverse Trendelenburg position, tourniquets should be applied to the extremities, and oxygen should be administered under positive pressure. Hypoxia developing as a result of pulmonary edema increases the stimulus for further pulmonary secretions, which reflex may be inhibited by oxygen under positive pressure. Intravenous aminophylline may be of some value, but atropine should not be used for, by increasing the heart rate, it decreases cardiac output.

Laryngeal injuries result from traumatic endotracheal intubation, either through the use of too large a tube, or from attempt at intubation under too light anesthesia. Most laryngeal injuries heal spontaneously, but when they occur in young children, they may result in fatal laryngeal edema. When laryngeal edema occurs or when it might be expected to occur in children, the use of an aerosol oxgyen tent with a detergent added to the vapor may prove lifesaving. Tracheotomy equipment should be immediately available and should be used on the first indication of persistent respiratory difficulty.

Liquid ether pneumonitis is mentioned only as a precaution against its occurrence. Overfilling of the ether vaporizer and sudden release of a kinked tubing from the ether machine are the

commonest causes of this accident. Ether pneumonitis is a definite phlegmon of the pulmonary epithelium and requires prolonged positive pressure oxygen and supportive and antibiotic therapy.

During the administration of an anesthetic, coughing and laryngospasm may occur with sudden increases of anesthetic concentration and diaphragmatic or periosteal stimulation under light anesthesia. Respiratory arrest occurs with an overdose of the anesthetic agent or with massive doses of curariform drugs. The occurrence of the cessation of respiration in itself should cause no alarm, but treatment should be immediate. The anesthetic should be withdrawn and artificial respiration should be applied by intermittent compression of the rebreathing bag of the anesthetic machine. Manual compression of the patient's thoracic cage is heroic treatment but unnecessary when an anesthetic machine and oxygen are available.

Atelectasis results from a combination of excessive secretions trapped in a major bronchus by depressed respirations. This condition is most apt to occur in surgery of the upper part of the abdomen, where there is continued and prolonged retraction against the diaphragm with consequent compression of the lower lobes of the lungs. Its frequency of occurrence may be decreased by the careful use of muscle-relaxant drugs during surgery, by the judicious use of sedatives, and by encouraging frequent coughing postoperatively.

Circulatory Accidents

Hypotension occurring during a surgical procedure on the anesthetized patient usually falls into two classifications. The first of these, primary or neurogenic shock, occurs with prolonged stimulation under light anesthesia, as a result of prolonged abnormal operative positions, or as a result of vagal or traction reflexes. It is characterized by a fall in systolic pressure of considerable degree with only a slight fall in diastolic pressure and little change in pulse rate. The condition is due to a peripheral vasodilatation, is usually transient, and responds rapidly to the use of any of the vasopressor drugs. Secondary or surgical shock results from excessive traumatic manipulation, blood or fluid loss, or peritoneal contamination. This type of shock is characterized by a decided fall in both systolic and diastolic pressures with a definite increase in pulse rate, profuse cold perspiration, peripheral cyanosis, and sighing respirations. Physiologically there is present a high degree of peripheral vasoconstriction, and consequently the use of vasopressor or constrictor drugs is of no value. Treatment consists of the use of plasma volume expanders such as dextran, plasma, or blood until the pulse and blood pressure reach preshock levels.

Hypertension occurs under anesthesia usually as a result of carbon dioxide retention due to soda-lime exhaustion, respiratory obstruction, injudicious use of muscle-relaxant drugs, or the overuse of pressor amines. Hypertension resulting from such exogenous sources results in increased bleeding and hyperventilation with exaggerated abdominal movements, and may produce a rupture of sclerotic blood vessels.

Arrhythmias occurring under anesthesia, be they extrasystoles, auricular fibrillation, or ventricular fibrillation, are cause for concern. In the presence of adequate oxygenation and adequate elimination of carbon dioxide, arrhythmias rarely occur. The use of epinephrine, particularly when cyclopropane is being administered, may result in ventricular fibrillation. The treatment of the lesser arrhythmias consists of discontinuing the anesthetic and assisting the normal respiratory movements by manual compression of the rebreathing bag. The gaseous or vapor anesthetic should be frequently emptied from the anesthetic bag during this process. Ventricular fibrillation may be diagnosed by a sudden absence of pulse and blood pressure occurring between two beats with cessation of respiration, and it requires heroic measures. The left thoracic cage should be opened immediately without aseptic preparation in the fourth interspace, and the heart should be massaged vigorously and at a rate of 30 to 40 times per minute. At the same time artificial respiration with oxygen should be maintained, preferably through an endotracheal tube or with a bag and mask if a tube is not available. A mixture of 9 cc. of 1 per cent procaine solution and 1 cc. of 1:1000 epinephrine solution is suggested by some for injection into the left ventricle. A defibrillator should be used if available. Massage should be continued until normal rhythm is restored or until all cardiac activity ceases. The sooner cardiac massage is started following the onset of ventricular fibrillation, the greater the likelihood of the re-establishment of a normal rhythm. There is no time for less heroic measures, consultations, or procrastination.

Cardiac arrest, occurring usually from oxygen lack to the myocardium from any cause, requires the same immediate treatment as ventricular

fibrillation. The atonic heart, however, will not respond to the use of a defibrillator, but continuous and vigorous massage will maintain the circulation.

Cerebral Accidents

Cerebral complications of anesthesia are invariably the result of anesthetic mismanagement somewhere else along the physiologic tree. Cerebral thrombosis may result from a prolonged period of untreated hypotension, and hemorrhage may occur as a result of a hypertensive episode during anesthetic induction or maintenance. Anoxia and prolonged hypoxia, however, are the most frequent of the cerebral complications. Even a transient period of cerebral anoxia or prolonged hypoxia will produce irreversible damage to the nervous system and primarily to the frontal lobes. All cerebral oxygen lack results in the development of cerebral edema with signs indicative of increased intracranial pressure such as vomiting, reflex changes, respiratory irregularities, coma, convulsions, and even death. The treatment of cerebral anoxia, when it occurs, must be undertaken without delay to prevent permanent damage to the brain. The patient's head should be elevated, convulsions should be controlled with intermittent administration of ether, the resultant hyperthermia should be treated with alcohol sponges and antipyretics, and human serum albumin should be given intravenously in an attempt to produce cerebral dehydration. If unilateral convulsions occur, the contralateral stellate ganglion should be blocked in an endeavor to increase the cerebral circulation. Oxygen by tent or nasal catheter is a necessity.

Convulsions occurring under anesthesia are usually due to retention of carbon dioxide, but may occur as a result of toxemias, overdosage of atropine or vinethene, and dehydration hyperthermia in children. Their treatment consists of adequate oxygenation, intravenous fluids, short-acting barbiturates, and correction of the causative factor.

Peripheral Accidents

Among the peripheral injuries or accidents that may occur under anesthesia, one of the commonest is the development of gastric dilatation. This condition is most prone to occur in the patient with an obstructed airway with resultant "air sucking" due to increased respiratory effort. Gastric dilatation should be suspected postoperatively in every case in which there are a rapid pulse, a fall in blood pressure, and distress in the upper part of the abdomen when the other signs that might suggest shock are not present. Treatment consists in the insertion of a Levin tube with gastric suction for a few hours. Fall in pulse rate and elevation of blood pressure occur almost immediately following gastric intubation.

The commonest nerve palsies occurring under anesthesia are those involving the ulnar and peroneal nerves. The ulnar nerve is particularly vulnerable in the olecranon fossa because of pressure on the side of the operating table. Two to six weeks are required for return of function of this nerve following injury. The peroneal nerve may be injured when patients are maintained in stirrups over a protracted period. It is now customary in most institutions to pad knee crutches and stirrups with a 1/2 inch thickness of foam rubber to prevent injury of the peroneal nerve and also thrombophlebitis due to pressure on the popliteal vessels.

Back injuries may result from improper positioning on the operating table and most commonly occur when the patient's legs are placed in or taken out of the stirrups one at a time. Both legs should be raised and lowered together to prevent undue strain on the sacroiliac and lumbosacral joints.

Eye burns and injuries may occur from liquid ether during open drop anesthesia or from irritation of the anesthetic gas in inhalation anesthesia. The eyes of elderly patients, infants, and patients with Graves' disease are particularly susceptible. A small amount of any type of ophthalmic ointment placed in the patient's eyes after induction of anesthesia will prevent conjunctival irritation and corneal ulceration. Sloughs at injection sites result from the intravenous injection of irritant drugs or the extravascular injection of the intravenous barbiturates. When they occur, phlebitis and periphlebitis are best treated by the application of moist heat and elevation, and severe cases may require debridement or sympathetic blocks to relieve the pain and swelling.

The commonest complication of spinal anesthesia is postspinal headache. Its incidence may be minimized by the use of small caliber spinal needles and avoidance of trauma to the dura. When such a headache occurs, the use of the supine position, epidural saline, caffeine and analgesics may be of some benefit. The neurologic sequelae of spinal anesthesia, namely, nerve root neuralgias, cauda equina syndrome, and paralyses,

are best avoided through the careful introduction of the spinal needle and the avoidance of too concentrated solutions of anesthetic drugs. If the patient complains of pain in either extremity or in the perineum at the time the needle pierces the dura, the needle should be withdrawn and reinserted, for it is undoubtedly within a nerve root sheath and injection of the drug in this location may produce permanent neurologic damage.

Tracheal collapse may occur during the course of a thyroidectomy when adenomatous tumors have caused erosion of one or more tracheal rings. Diagnosis is made by observation on the development of tracheal obstruction during the course of the surgery. Attachment of the strap muscles to the collapsed trachea may suffice to correct the condition, but tracheotomy may become necessary. Pulmonary embolism and coronary thrombosis may occur during the course of the most skillful administration of an anesthetic, and treatment is the same whether the patient is anesthesized or not. Air embolism is an uncommon condition that may occur with laceration of the jugular vein, and diagnosis may be confirmed, when the condition is suspected, by the auscultation of air within the heart chambers. Treatment consists of immediate Trendelenburg position, vasopressor drugs and plasma intravenously, and oxygen with or without artificial respiration as required. Thrombophlebitis, while its occurrence is usually during the postoperative period, frequently has its groundwork laid, as mentioned previously, in improper positioning on the operating table with pressure over main venous trunks. Treatment consists of the use of adrenergic blocking agents, elevation of the involved extremity, anticoagulants and sympathetic nerve blocks.

Transfusion reactions under anesthesia are often masked by the anesthetic, but should be suspected in any case in which cyanosis, urticaria, or abrupt changes in pulse and blood pressure develop within a short time of the onset of administration of blood. If it is determined that the patient has received incompatible blood, the patient should be alkalinized immediately with intravenous molar lactate or sodium bicarbonate to prevent renal failure, and compatible blood should be administered to replace that destroyed by hemolysis.

Conclusion

Safety is the watchword in the administration of any anesthetic. Careful patient preparation and premedication will prevent many anesthetic accidents. How dangerous is that request for "just a whiff of gas" for the 300 pound patient; or, "give the patient just a little pentothal for this case won't take long." While some surgery may be considered minor, there is no such thing as a minor anesthetic. From the moment the mask is placed over the face of a patient or the needle inserted into a vein, that patient's life is in the hands of the anesthetist at the head of the table. The incidence of difficulty during anesthesia will be appreciably decreased if the anesthetist is considered part of the surgical team and is permitted to administer the anesthetic he considers most suitable, and more important, with which he is most familiar.

420 West Lafayette Street.

Discussion

Dr. Ralph S. Sappenfield, Miami: I am happy that an anesthesiologist, especially Dr. Carron, has had the opportunity to speak to this meeting. I appreciate his careful and detailed organization of such a big subject. Time seems to be a factor that keeps coming up when we think of accidents and complications occurring with surgery. I should like to emphasize Dr. Carron's point that we always have time to administer premedication since it can be given intravenously and also that we now have bellafoline® to add to the premedicant. Bellafoline® dries as well as scopolamine, but like atropine provides no psychic sedation but will obtund vagal reflexes more than either. There is a mutual problem of the surgeon and the anesthesiologist to check the patient preoperatively, to have the blood volume, the red blood cell count and/or the hematocrit reading within normal range. The failure to do so accounts for increased morbidity and mortality postoperatively.

Secondly, time comes into play when the surgeon, not having seen his patient in the hospital, wishes to speak to him before he is put to sleep. What is said the patient does not remember if he is properly premedicated. The surgeon then goes into the scrub room to use one of the new scrub soaps such as pHīsoHex® or Septasol,® returning to the operating room after a three to five minute scrub. During this short time he expects the patient to be anesthetized, to be positioned, to be prepared, to be draped, and all waiting his entrance. This expectation tends to cause the anesthetist or anesthesiologist literally to slug the patient to sleep in order to accomplish these objectives. This tendency definitely increases the percentage of complications.

Thirdly, time is important throughout the procedure, and it should be conserved on every turn. Even with good anesthesia, increased time increases complications.

Dr. Carron spoke only briefly of spinal anesthesia in the presence of intestinal obstruction. May I remind you of the resultant constriction of the intestine by the circular fiber contraction which many times causes the viscus to become perforated? Spinal anesthesia should never be used in the presence of intestinal obstruction.

Time is again a potent factor when a complete laryngospasm occurs. When a laryngoscope or intratracheal tube is not available, or one feels he is not capable of using either, one can usually find a 2 cc. syringe and 1 to 2 cc. of water or saline. With a hypodermic needle through the neck into the trachea, the solution can be injected. The patient will then cough to expel it, thereby breaking his own laryngospasm.

Laryngeal edema in children seems to be of infrequent occurrence. In a recent conference of anesthesiologists from the Southern states, it was brought out that most

tonsilectomies are being performed under intratracheal anesthesia. It is easy to induce, rarely causes trauma, and offers a great deal more safety. With a free and clear airway, gastric dilatation rarely occurs, and with this avoided, another etiologic factor for a fatality is removed.

Again time is important if there has been a complete circulatory failure. Anesthesiologists should say to the surgeon, "Shall I open the chest, or will you?" As in the story we all know, "If you are going to argue about it, let's call the whole thing off."

One point that Dr. Carron did not have time to list is that blood introduced in the large arteries during massage of the heart will have a greater value than when introduced in the peripheral circulation. Many times there is not a sudden circulatory failure, for the process has been progressing for many minutes before failure occurs. The warning flags were not seen. Even at times we set the stage for this occurrence by the administration of too many drugs. I am a firm believer in the fact that with the increase in the number of drugs used there will be an increase in the number of complications.

Early in Dr. Carron's paper he spoke of neurogenic shock occurring with the stimulation under light anesthesia. This we are seeing with increased frequency, where anesthetists are guilty of substituting muscle relaxants, curariform drugs, for adequate anesthesia. It is an easy pitfall.

Again I should like to thank Dr. Carron for his contribution.

Cause and Treatment of Nonunion of Tibial Fractures

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Failure of union occurs more frequently in fractures of the tibia than of any other bone except the neck of the femur. The principal cause of tibial nonunion is imperfect immobilization of the fragments. Any new development, therefore, in the treatment of fractures which will provide better immobilization of the fragments should be employed in the treatment of tibial fractures if possible. Correct insertion of intramedullary nails in selected cases of tibial fractures seems to provide the required immobilization and thus should reduce the incidence of nonunion. Likewise, the better fixation of fragments provided by intramedullary nails is proving helpful in the treatment of cases of established nonunion of the tibia when combined with the application of suitable bone grafts.

The value of bone grafts to promote union is well established. Considerable discussion, however, has centered around the merits of various kinds of bone grafts, for example, autogenous or homogenous, cortical or cancellous, and massive or shavings or chips. Enough clinical experience in the use of these various kinds of grafts, as well as reliable experimental observations, has accumulated to indicate which bone grafts are preferable. This paper will review the subject of intramedullary fixation of tibial fractures and discuss the kinds of bone grafts that should be used in the treatment of nonunion of the tibia.

Intramedullary nails have been used most frequently and successfully to treat fractures of the shaft of the femur. Success has depended chiefly upon several principles. First, a long, rigid metal nail or tube can be safely inserted into the full length of the medullary canal of the femur and is well tolerated by the bone for many months. Secondly, such a rigid nail, passed through the full length of the medullary canal of the femur, provides almost perfect immobilization of fragments provided it fits snugly in the canal and extends far enough beyond the fracture line to secure a good purchase on each fragment. Finally, the internal fixation thus provided is so secure and strong that prolonged external fixation is unnecessary, muscles and joints may be exercised almost from the beginning, and weight bearing may be permitted before the callus has completely calcified. Union, therefore, is more certain, the periods of hospitalization and disability are shortened, and the possibility of muscle atrophy and stiffness of joints is diminished.

The same principles that have made the use of intramedullary nailing successful in femoral fractures are applicable to its use in tibial fractures. Actually, intramedullary nails are rarely employed for tibial fractures because the technical problems of introducing them are greater and somewhat different from those encountered in

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femoral fractures. Retrograde insertion of an intramedullary pin in the proximal fragment of the tibia cannot be accomplished without opening the knee joint. This adds considerable risk to the procedure and probably should not be done except in highly selected cases. The method generally used requires the making of a slot in the inner tibial condyle through which the pin is directed down the canal and into the distal fragments. The hour-glass shape of the tibial medullary canal makes it impossible to have a nail or tube of uniform size fit snugly in the full length of the canal. Nested U-shaped pins or flexible nails therefore are required and when one of these has been successfully introduced, the tibial fragments are still not fixed as securely and certainly as are femoral fragments. Hence, there is need for external fixation with plaster for most of these fractures until early formation of callus takes place. In 1949 in a report on delayed callus formation in 8 of 56 cases of tibial fractures treated with intramedullary nails Lauritzen[1] wrote, "We can scarcely fail to lay the blame for delayed callus on the early weight bearing in these cases where the nail undoubtedly afforded insufficient fixation." Every effort, therefore, should be made to use pins which will provide maximum fixation and purchase on the fragments, and even when these seem to have been satisfactorily accomplished, it is probable that a long leg plaster should be worn for the first four to five weeks until the fragments are welded together with firm early callus. Then a walking plaster might be used, and, later, weight bearing without external support.

In relatively few cases of tibial nonunion, intramedullary nails have been employed for internal fixation in connection with bone grafting procedures. They have been so helpful in obtaining union in these cases, however, that it is probable they will be used more and more frequently as surgeons become more familiar with the exacting technic required for their insertion. The intramedullary pin provides firm fixation of the fragments in good position, leaving the entire circumference of the cortex available for the application of multiple bone grafts.

Nonunion with Loss of Substance

For nonunion of the tibia, especially when a defect of the bone exists, use of massive onlay grafts has been generally accepted as the method of choice. These grafts, consisting of the full thickness of the tibial cortex, are firmly attached to the tibial fragments with screws. In cases with defects more than 1 cm. long, dual grafts are often applied, one on either side of the bone. The rigid cortical bone, firmly attached with screws, has been considered essential to securing union because it seems to be the only way to provide complete immobilization and at the same time a stimulus to new bone formation. It has been generally recognized, however, that dense, cortical bone grafts are slowly replaced with new bone whereas cancellous grafts are replaced more rapidly.[2] When intramedullary pins are employed for fixation, cancellous grafts may be used to fill the bony defect or surround the line of nonunion; fixation with screws is not essential, thus avoiding additional foreign bodies and the trauma incident to their insertion; and external fixation may be discontinued sooner to permit exercise of muscles, motion of joints and weight bearing, all of which are essential to a good functional result. Despite the probable advantages of intramedullary nailing combined with the use of cancellous grafts for nonunion of the tibia, there will always be a certain number of cases, however, for which the onlay tibial grafts will be better adapted.

Separation of the tibial fragments of less than 1 cm. often results from early union of the fibular fracture, at full length, while gradual absorption of the ends of tibial fragments takes place, thus producing a gap which new bone cannot cross readily. In such cases it is essential that oblique osteotomy of the fibula be performed so that the tibial fragments can be forced together. This osteotomizing of the fibula is a necessary adjunct to other measures to promote union of the tibia, and one that should never be overlooked.

Delayed Union and Nonunion of Tibia With Good Apposition and Alignment

In many cases after three to six months' fixation in plaster, even if good position has been maintained, there will be little or no evidence of union, usually because of poor immobilization in plaster. In such cases it is desirable to take steps to promote more rapid union. Of the many methods that have been used, two are of proved value: (1) multiple drill holes crossing the fracture site, and (2) application of onlay grafts without screw fixation as advocated by Phemister.[3]

Multiple drill holes crossing the line of fracture obliquely from various directions permit ingrowth of blood vessels and stimulate repair. This procedure can be accomplished through a minimal

exposure and is followed by little or no reaction, swelling or pain. After the drill holes have been made, a snug, long leg plaster should be applied.

Phemister[3] proved that it is not essential to expose and freshen the ends of fragments and ream out the marrow cavities as was generally done before grafts were applied. When the fragments are well apposed and the alignment satisfactory, it therefore suffices to freshen and level one or two surfaces of the tibia across the fracture line and lay bone grafts alongside in contact with the raw surfaces. Phemister[3] found that screw fixation is not essential and that multiple short cortical or cancellous grafts serve to hasten callus formation and solid union. Osteotomy of the fibula is often required in addition, and application of a well fitted, long leg plaster is generally essential.

Selection of Grafting Materials

Many articles have appeared advocating homogenous bone grafts preserved by chemicals or by freezing, and others have emphasized the advantages of cortical grafts as opposed to those of cancellous bone. This disagreement has served to confuse the average reader. Doubtless each kind of graft has a field of usefulness; certainly no one type is universally applicable. Enough experience has now accumulated, however, to justify certain criteria in the selection of grafting materials: autogenous grafts are more certain to survive and promote osteogenesis than homogenous bone; cancellous grafts are more readily revascularized and replaced than cortical grafts and therefore usually result in more rapid union; fresh autogenous grafts are more likely to survive and less prone to produce infection than homogenous grafts preserved by freezing or in chemical solutions, although the latter may be used in selected cases; cortical grafts are most useful when strength and rigidity are of primary importance, and their osteogenic power can be enhanced by the addition of cancellous bone; and cancellous grafts are preferable whenever bone repair or bone replacement is delayed or absent.

Conclusions

1. Intramedullary nailing together with suitable bone grafts is an effective method of treatment of nonunion of the tibia.

2. Intramedullary nails supplemented by cancellous bone grafts are applicable to some cases of tibial nonunion with loss of substance which ordinarily are treated with massive onlay grafts.

3. Osteotomy of the fibula is a useful adjunct in the treatment of tibial nonunion with slight distraction of fragments.

4. Delayed union or nonunion of the tibia with good appositon of fragments usually will respond to small onlay grafts applied without screw fixation.

5. Autogenous grafts are preferable to homogenous grafts, although the latter may be used when the former are not available.

6. Cancellous grafts are replaced with callus more rapidly than cortical grafts, but the latter are essential when the problem requires strength and rigidity.

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Prytania and Aline Streets.

MEDICAL DISTRICT MEETINGS

Tallahassee, Oct. 19, 1953

Tampa, Oct. 21, 1953

St. Augustine, Oct. 20, 1953

West Palm Beach, Oct. 22, 1953

Congenital Malformations of the Thoracic Aorta

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The subject of malformations of the thoracic aorta encompasses mainly three categories of conditions: (1) patent ductus arteriosus; (2) aortic coarctation, and (3) the so-called vascular rings. The discussion of these conditions is important since each condition may lead to untimely death, and, at the same time, many patients with one or another of these malformations are candidates for relief or cure by surgical means.

Patent Ductus Arteriosus

In the fetus the ductus arteriosus is a vital channel carrying blood ejected from the right ventricle into the descending aorta from which vessel it flows to the placenta for exchange of oxygen and other substances. Normally, after birth the ductus arteriosus closes, at first, in all probability, by spasm. Later the lumen of the vessel becomes closed anatomically. Usually by a month after birth anatomic closure is complete. In some instances the anatomic closure is accomplished within two weeks from the time of birth.

If the lumen of the ductus arteriosus remains persistently patent, an abnormal shunt occurs. After birth the pulmonary arterial pressure normally is lower than the aortic pressure. Under these circumstances the flow of blood through the ductus arteriosus is in the reverse direction from that which occurs in the fetus. In the postnatal state the flow is from aorta into the pulmonary arterial system.

The shunted blood, which is already completely saturated with oxygen and represents about half of the average output of the left ventricle, then flows through the lungs to the left side of the heart and to the aorta, where the shunt is repeated. The right ventricle does not carry any of the blood involved in the shunt.

Under ordinary circumstances the burden of the shunt is carried by the left ventricle, which becomes dilated and hypertrophied. The left ventricle may ultimately fail, and this complication may in turn be followed by right ventricular failure. It must be emphasized, however, that failure of the left ventricle may be associated with death from pulmonary edema without right ventricular failure existing.

In addition to one or another manifestation of cardiac failure, the patient with a persistently patent ductus arteriosus is subject to the possibility of bacterial intravascular infection. When this occurs, it involves primarily either the ductus arteriosus itself or the major pulmonary arteries opposite the mouth of the ductus where the lining is traumatized by the jetlike stream of the shunted blood.

The two major complications of patent ductus arteriosus, namely, cardiac failure and bacterial infection, usually do not occur until adult life. It must, however, be emphasized that, although there is this delay in the majority of cases, left ventricular failure has occurred during infancy as a result of persistent patency of the ductus arteriosus. Furthermore, it must be emphasized that unless surgical closure of the ductus arteriosus is carried out in infants who have this complication, death during this early period of life may be caused from the resulting pulmonary edema.

It is axiomatic that the so-called machinery murmur of patent ductus arteriosus does not occur during the first few years after birth. Failure to realize this situation may result in overlooking the possibility of patent ductus arteriosus when in fact that condition represents the problem in a given case. In infancy the murmur of patent ductus is usually systolic and has a tendency to be loudest over the basal portion of the heart, although this localization of the murmur cannot always be demonstrated.

The history of the patient who is suffering from the effects of left ventricular failure incident

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to patent ductus arteriosus is not specific and may be duplicated by other conditions in which left ventricular failure plays a role. Some of these conditions are: ventricular septal defect, coarctation of the aorta, endocardial sclerosis, anomalous origin of the left coronary artery from the pulmonary trunk, subaortic stenosis, mitral insufficiency and paroxysmal tachycardia. Many patients have histories of poor feeding, failure to gain weight and attacks of "bronchitis" or "pneumonia." During these attacks cyanosis, which is not present between attacks, may be present. In all probability the attacks which are attributed primarily to pulmonary infection represent basically attacks of acute left ventricular failure with associated pulmonary edema. Careful examination and treatment are urgent for such patients because death may occur unexpectedly during an attack of pulmonary edema.[1-3]

In the ordinary case of patent ductus arteriosus the adult or adolescent patient has a pulmonary pressure within the range of normal. The circulatory disturbance in such cases has already been reviewed. A few patients having patent ductus arteriosus may have elevated pulmonary pressures which far exceed the normal range and approach or equal systemic pressures. In such cases a significant burden is placed on the right ventricle manifested by roentgenologic and electrocardiographic characteristics of right ventricular hypertrophy as well as by poor tolerance for exercise on the part of the patient. Since the volume of the shunt through the ductus arteriosus is in part dependent on the degree of difference in pressure between that in the aorta on one hand and that in the pulmonary arteries on the other, the magnitude of the shunt tends to fall when the pulmonary pressure rises. In extreme cases the direction of the shunt may be reversed with venous type blood flowing from the pulmonary arterial system into the aorta. In cases in which the pulmonary pressures are significantly elevated and the volume of the arteriovenous shunt is decreased, the left ventricle is proportionately relieved of the burden of the shunt. On the contrary the burden of the right ventricle is increased, and the chances of right ventricular failure become great.

The factors responsible for significant elevation of the pulmonary arterial pressure which occurs in the minority of patients having patent ductus arteriosus are probably several. They include organic occlusive lesions in the pulmonary vascular bed, functional response of the pulmonary vascular bed, excessive flow of pulmonary blood and left ventricular failure.

The outlook for an essentially normal cardiovascular system after surgical interruption of the ductus arteriosus is less certain for the patient having patent ductus arteriosus complicated by pulmonary hypertension than for the patient having an uncomplicated case of patent ductus arteriosus. Indeed, some wonder whether closure of the ductus arteriosus results in a fall in pulmonary pressure of sufficient degree to relieve the burden on the right ventricle. While this is still an unsettled problem as regards all cases, the experiences of several at the Mayo Clinic have been that in cases of pulmonary hypertension with patent ductus arteriosus ligation of the ductus arteriosus may, in some cases, be followed by significant reduction in pulmonary arterial pressure.

Aorticopulmonary Septal Defect

Aorticopulmonary septal defect is characterized by a window-like communication between the ascending aorta and the pulmonary trunk.[4] Though rare, this condition is to be considered in the differential diagnosis of patent ductus arteriosus since the circulatory abnormalities of the two conditions are essentially identical. Especially is the diagnosis of aorticopulmonary septal defect to be considered when a murmur similar to the machinery murmur of patent ductus arteriosus is heard best at some focus removed from the left subclavicular region.

Although in isolated cases the defect has been closed surgically, as yet a standard operative procedure has not been devised for the closure of this abnormal communication.

Aneurysm of an Aortic Sinus (Sinus of Valsalva)

Aneurysms of an aortic sinus usually involve the right aortic sinus and less commonly the posterior sinus.[5] These aneurysms may communicate with either the right atrium or ventricle from before birth or they may rupture secondarily into either of these cardiac chambers at some time after birth.

If a congenital communication exists between the right side of the heart and the aorta, a continuous murmur, usually loudest in the right side of the precordium, may be heard at the time of the patient's birth.

When an aneurysm of the aortic sinus ruptures some time after birth, the patient's history is usually one of well being until sudden onset of dysp-

nea and of a continuous precordial murmur. Although a communication between the aorta and a right-sided cardiac chamber is not amenable to surgical treatment at the time of this report, such a condition enters into the clinical differential diagnosis of patent ductus arteriosus because of the continuous nature of the precordial murmur.

Coarctation of the Aorta

In coarctation of the aorta, the malformation is one of the tunica media of the aorta. The basic narrowing is not caused by fibrous tissue; it is a true deformity of the aortic wall involving all parts of the media except that of the lower portion. There is a thickening of the media which causes profound narrowing of the lumen.

In classifications of coarctation of the aorta reference frequently is made to the so-called infantile and adult types. These terms are not useful. A classification which takes into account the questions as to whether the coarctation is proximal or distal to the ductus arteriosus and also whether the ductus arteriosus is patent or closed is preferable.[6,7] Accordingly, the following classification of aortic coarctation is offered:

A. Coarctation of aorta distal to ductus arteriosus
   1. With ductus arteriosus closed
      a. With branches of aortic arch normal
      b. With stenosis or atresia of origin of left subclavian artery
      c. With stenosis of origin of right subclavian artery
      d. With origin of right subclavian artery beyond coarctation as fourth branch of aorta
   2. With ductus arteriosus patent

B. Coarctation of aorta proximal to ductus arteriosus
   1. With ductus arteriosus closed
      a. Coarctation distal to origin of left subclavian artery
      b. Coarctation proximal to origin of left subclavian artery
   2. With ductus arteriosus patent

Coarctation is considered to be formed during fetal life, and the development of collateral vessels during this period depends on the position of the aortic narrowing with respect to the ductus arteriosus. Whether or not collateral vessels develop will be important to the patient after birth and after the ductus closes. If the coarctation is distal to the ductus, the normal fetal flow from ductus into the descending aorta is impossible, and the collateral vessels develop if the fetus is to survive and to get blood from the heart to the placenta. Coarctation beyond the ductus is the commonest variety. In this type of case collateral vessels have a chance to develop in fetal life, and the patient may be reasonably well off after birth when the ductus closes.

If the coarctation on the other hand lies proximal to the ductus arteriosus, the fetal circulation is disturbed little, if at all, since the blood from the right ventricle and ductus can readily enter the descending aorta. It is much like a normal fetal circulation. The stimulus for collateral development is deficient, and few or no collateral channels develop to by-pass the coarctation.

The clinical manifestations of coarctation vary greatly depending on whether the coarctation is distal or proximal to the ductus. In the usual type of coarctation the aortic narrowing is distal to the ductus, and the latter is closed. The branches of the aortic arch are normal. The patients in cases of this type have hypertension demonstrated by elevated brachial blood pressure, with absent or weak femoral pulsations. An aortic diastolic murmur may be present.

The extensive collaterals may be apparent as abnormal arterial pulsations in the interscapular regions. The same feature may be demonstrated roentgenographically by notching of the ribs. The latter sign, although frequently searched for if the patient is suspected of having coarctation, is not invariably present in adult patients and is usually absent in children. The electrocardiogram may help in some cases, but may not be an aid to diagnosis. Left ventricular strain may be apparent.

Coarctation distal to a closed ductus arteriosus but with associated abnormalities of the branches of the arch presents interesting clinical pictures. These are manifested by inequality in the force of the radial pulses and of the brachial blood pressures. When the left subclavian artery is either atretic or stenotic, the left radial pulse is absent or weak and the left brachial pulse usually cannot be measured with the ordinary blood pressure cuff, while hypertension and forcible pulses may be demonstrated in the right arm. If notching of the ribs is evident in the roentgenogram, this feature is limited to the right side. The femoral pulses are weak or absent. An identical picture is found in those cases in which the coarctation is proximal both to the ductus arteriosus and to the left subclavian artery and in which the ductus

arteriosus is closed.

When coarctation is present distal to the closed ductus and associated with stenosis of the right subclavian artery, there is likewise inequality in the pulses and blood pressures of the upper extremities, but the picture is the reverse of that of the case wherein the left subclavian artery is narrow. Origin of the right subclavian artery distal to the coarctation produces a clinical picture like that in the patient with coarctation and with stenosis of a normally arising right subclavian artery.

Coarctation of the aorta distal to a patent ductus arteriosus is associated with well developed collaterals. The individual patient presents the clinical manifestations commonly associated with aortic coarctation and patent ductus arteriosus. As a consequence of the greatly increased flow through the shunt, occlusive vascular lesions develop in the lungs and eventually evidence of patent ductus arteriosus complicated by pulmonary hypertension may be added to the clinical makeup of the patient.

In general, patients with coarctation distal to the ductus arteriosus, whether the ductus remains open or becomes closed, live longer than patients in whom the coarctation is proximal to the ductus arteriosus. Even the patients who have a better prognosis usually do not reach a full span of life since they are faced by a number of potential complications.

Cardiac failure resulting from the existing hypertension is one of these complications.[8] In some patients cardiac failure may be caused by insufficiency of a coexisting bicuspid aortic valve. This valvular malformation may be found in about three fourths of the patients with coarctation. In some of these, bacterial endocarditis of the aortic valve may be superimposed. Another complication that occurs in patients with coarctation of the aorta is a tear in the proximal aorta, a typical dissecting aneurysm of the aorta which usually leads to hematopericardium and death. Occasionally a patient having coarctation also has a saccular aneurysm beyond the coarctation. The occurrence of aneurysms in the circle of Willis is common in cases of coarctation, and in an occasional patient one of these may rupture, leading to subarachnoid hemorrhage. Dilatation of the anterior spinal artery may occur since that artery takes part in the collateral circulation. Rarely thrombosis of the anterior spinal artery with typical anterior spinal artery syndrome may occur.

As stated previously, when the coarctation lies proximal to the ductus arteriosus, collateral vessels which would by-pass the coarctation develop poorly or not at all. If the ductus remains open, the descending aorta is supplied by the right ventricle. Thus, only part of the right ventricular blood flows to the lungs; the remaining amount enters the descending aorta. The blood which enters the descending aorta re-enters the right ventricle after it has traversed the systemic circulation of the lower part of the body. The left ventricle is excluded from carrying the blood which supplies the part of the body below the level of the coarctation. Clinically the patients in cases of this type have good femoral pulsations, but the lower portion of the body may be cyanotic, since it is supplied with venous type blood. The clinical picture is entirely different from that in the usual type of coarctation. Functional disturbances result from the existing pulmonary hypertension and right ventricular strain.

When coarctation is proximal to the ductus arteriosus and the ductus closes, all of the blood which leaves the right ventricle traverses the lungs and is then expelled by the left ventricle. In the presence of inadequate collaterals, the coarctation may be considered as a significant barrier to emptying of the left ventricle, resulting in left ventricular strain and even left ventricular failure.[7,9,11] Such problems are observed in the newborn. As a rule the clinical manifestations of left ventricular failure in such cases do not differ from those of left ventricular failure resulting from simple patent ductus arteriosus or other conditions already listed. Usually there is roentgenologic and electrocardiographic evidence of left ventricular hypertrophy. Evidence of right ventricular hypertrophy may coexist. An important sign leading to the correct diagnosis is absence of femoral arterial pulsations. Kirklin and associates[12] have reported the case of a 10 week old infant in whom successful resection of the segment of aorta containing the coarctation and performance of an end to end anastomosis of the aorta were accomplished with disappearance of evidence of coarctation and of left ventricular failure.

Vascular Rings

The so-called vascular rings comprise a large number of vascular patterns of the aorta and its branches which collectively have the characteristics of producing undue pressure against the esophagus alone or in association with the trachea. Detailed descriptions of the characteristics of each of these

vascular configurations are in the literature.[13] Some patients having these abnormalities live a full life with no symptoms referable to the vascular malformation. If symptoms are present, they usually appear in infancy or childhood. Two categories of disorders are manifested, one resulting from esophageal obstruction, the other from tracheal obstruction. Esophageal obstruction causes regurgitation of food and even liquids in most severe cases. Tracheal obstruction is manifested by cough, at times brassy in character, wheezing and retraction of the head. At times hyperflexion of the spinal column is evident. In cases of severe tracheal obstruction inspiratory intercostal and supraclavicular retraction may be present. Pulmonary infection is common and may be the terminal complication. In some cases pulmonary infection constitutes the chief noticeable disorder, the patients being subject to recurrent attacks.

Since all of the vascular rings cause esophageal compression, whether producing symptoms of this disturbance or not, the simplest method of establishing the diagnosis of a vascular ring is to obtain an esophagram. If the condition exists, evidence of the deformity will be apparent in the upper portion of the thorax, usually at about the level of the third thoracic vertebral body. Bronchoscopic examination may reveal pulsating narrowing of the trachea, but this procedure is not as a rule necessary for the establishment of diagnosis of a vascular ring. Exact prediction of the anatomic nature of the malformation in a given case requires familiarity with the roentgenographic characteristics of the mediastinum. Treatment of patients having symptoms is surgical and is directed toward dividing those structures which would release the trachea and esophagus from the constricting effect of the vascular malformation, at the same time preserving vital vessels.[14]

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MEDICAL DISTRICT MEETINGS

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Any member interested in presenting a scientific paper at one of these meetings is urged to make application without delay to Dr. John D. Milton, 701 Huntington Bldg., Miami, or to any Councilor, or an officer of your county medical society.

You may either speak in your own district or as a guest essayist in some other district, if you prefer.

Miliaria: Pathogenesis and Treatment

A Review of Recent Advances

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The seemingly simple disease called prickly heat has in recent years been the subject of much experimental work and thought. This interest has been the result of intensive studies by dermatologists in connection with military action in tropical theaters of war. It is timely that the physician in this semi-tropical climate be made familiar with the recent progress in this field.

Incidence

Contrary to popular belief, there is no greater susceptibility of the blonde, fair-skinned or red-headed person than of the brunette. Also, obesity does not predispose to greater incidence of the disease.[1]

Relation to Salt Intake

With such a high proportion of the population on a salt-poor diet for various cardiovascular conditions, it is interesting to note the results of Fay.[2] A low or moderate salt intake, up to 14 Gm. daily, helps to avoid miliaria, whereas a large intake of over 28 Gm. daily aggravates and predisposes to a greater incidence of the disease. It is suggested that this aggravation by a high salt intake is due to the subject's overcompensating for salt lost by sweating, with the result that there is an upset in the osmotic balance in the blood, followed by an increased rate of sweating.

Horne and Mole,[3] in studying this question of salt relation to miliaria, concurred in Fay's findings and found that increased intake of water relieved the aggravated miliaria.

There is evidence, summarized by Gregeisen,[4] which suggests that the skin can store sodium chloride, and with less than enough water to dilute it to isotonicity. This might explain why an increased salt intake shows itself in some circumstances as a cutaneous lesion.

The turnover of salt and water in a hot climate may be large and may vary considerably from day to day, depending on the environment and on physical exertion. Thus, short term alterations in salt and water balances can easily take place, and may be responsible for the great fluctuations in the incidence of miliaria.

Interestingly, O'Brien[5] emphasized in this connection that the anidrosis associated with miliaria itself leads to an alteration of salt and water balance.

For these reasons, the patient on a salt-poor diet, especially if he has a senile or ichthyotic skin, must be provided for in regard to prophylaxis in miliaria.

Local Cutaneous Edema in the Pathogenesis of Miliaria

Pollitzer,[6] in 1893, said: "This condition is evidently due to imbibition of the stratum corneum with water or with sweat. An epidermis which is bathed in perspiration, retained, as it is, by wet underclothing, cannot cornify; and, in imbibing water, the cells swell, and swell in all directions, laterally as well as vertically. Cells which are well impregnated with fat cannot imbibe water, and therefore will not swell up and occlude the sweat ducts when soaked with perspiration." He then cited the freedom of the well oiled Negro from miliaria and the toll of the disease among Englishmen in India who take "a couple of tubs" a day.

These opinions by Pollitzer[6] were lately confirmed in O'Brien's work. Typically, there is a lack of manifest sweating in areas of miliaria. This is not due to impairment or lack of sweat formation, but to failure to deliver the sweat to the surface of the skin. This failure is apparently caused by horny plugs in the sweat ducts and/or by inflammatory reactions and edema constricting the terminal part of the duct.

The Horny Plug in the Pathogenesis

The significance of the horny plug is explained in the theory of Pollitzer,[6] namely, that the keratin of the stratum corneum swells through imbibition and so blocks the mouths of the sweat ducts. He suggested that the keratin swells be-

cause it is not protected by sufficient lipoid. Lipoid depletion is probably not the sole or direct cause of miliaria as seen in the tropics. Nevertheless, it is probably a direct cause of poral closure in many ichthyotic skins.

Infection in the Pathogenesis

It is possible that temporary waterlogging of the pore, whether or not it produces closure, may pave the way for infection by staphylococci. Arnold[7] has shown that edema of the stratum corneum causes an increase in the endogenous bacterial flora of the skin. O'Brien,[5] in applying solid culture mediums to the skin, caused the formation of parakeratotic plugs in sweat pores as the result of experimental staphylococcic infection. He also found that gram-positive cocci are identifiable with considerable regularity in the pores in the earliest lesions in miliaria.

Where infection is absent, he found, edema and increased temperature are together capable of producing only a transient degree of poral closure, as manifested in the mild process called miliaria crystallina. Excessive soaping, too, causes parakeratotic plugging of the sweat pores, but the mechanism of this is unknown; whether it occurs by lipoid depletion, staphylococcus infection, or by direct injury is undetermined. Walker[8] found that the Staphylococcus aureus resists the antiseptic action of soap more than other bacteria, and therefore is still present after soaping, to play a part in causing miliaria.

O'Brien[5] carried out the following experiment to prove that the evil side effect of soap might be wrought, at least partly, through lipoid depletion. A soldier, with a history of a normal skin, soaped both sides of his abdomen for two minutes, five times daily. After each soaping, he applied a bland toilet powder to the test side, and then inuncted lanolin into the control side.

After one day, a miliarial rash was evident on the test side (with the powder), but the control side remained normal. Treatments were continued, and biopsy specimens taken from each side on the twelfth day. At that time, the test area had become relatively anhidrotic.

Keratotic plugs developed on the test side, and the control side remained normal. One may conclude that soaping with the ordinary alkaline soaps is contraindicated in the case of recurrent miliaria.

Summary of Treatment Aims and Methods

1. Inhibit excessive sweating		Cooler environment
2. Promote evaporation and drying	by	Reduce work load
3. Prevent and counteract maceration		Fewer clothes
4. Increase heat loss by other routes		Drink fluids
		Little salt intake
5. Diminish swelling of keratin		Producing superficial desquamation with
6. Prevent formation of horny plugs and remove horny plugs present	by	
7. Reduce the concentration of irritating agents in the sweat		℞ Menthol 1% Glycerin 1% Salicylic acid 4% Alcohol 95% qs Sig: Dab on affected areas several times daily
8. Allay the periductal inflammation		A full erythema dose of cold quartz light every three days
9. Prevent lipoid depletion, especially in senile skin		Avoiding soaps
10. Avoid irritation of skin	by	Use pHïsoHex® in cleansing once daily only
11. Avoid poral infection		Anoint with an antiseptic baby oil, after washing.

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American Building.

ABSTRACTS OF MEDICAL ARTICLES

Effective Treatment for Black Widow Spider Bite. By Edmonson S. Couric, M.D. South. M. J. 45:1193 (Dec.) 1952.

Three cases are added to the literature describing poisoning from the bite of Latrodectus mactans, the black widow spider. In these cases treatment with epinephrine administered subcutaneously brought prompt relief from the severe symptoms, which include nausea, vomiting, shock and extremely severe muscular cramps.

In the first case, treated in 1937, the patient experienced severe pain in the left eye in addition to the symptoms mentioned, which were extreme. After failing to respond to morphine and other therapy, he was in a moribund state with muscles drawn in knots and jaws locked when administration of 10 minims of epinephrine brought dramatic relief almost immediately. With each recurrence of muscular cramps this drug gave relief within three minutes. The sight of the left eye was not regained, however, and at present, after 15 years, he can barely distinguish daylight from dark because of an embolus. Whether the sight would have been saved had epinephrine been administered sooner remains problematic. In the second case 8 minims of epinephrine, and in the third case 7 drops, brought complete relief from the severe symptoms within six minutes, and no further treatment was necessary.

In reviewing the literature, the author was unable to find a report of a case in which epinephrine had been used in the treatment of black widow spider bite. The usual treatment described was calcium gluconate intravenously and morphine with recovery taking several days, and in some instances there was fatal termination.

The Dysenteries in the Armed Forces. By Albert V. Hardy, Richard P. Mason, and Gerald A. Martin. Am. J. Trop. Med. & Hyg. 1:171-175 (Jan.) 1952.

Certain aspects of an epidemic in Korea, involving prisoners of war, are presented as illustrative of the peculiar nature of the problem of dysentery in the Armed Forces. The magnitude of this epidemic is described as some 150 major epidemics compressed into one. Ordinarily, an outbreak of enteric infections with 161 hospitalized cases with a fatality rate of 9 per cent, and some 800 milder nonhospitalized cases, would be regarded as a major epidemic, but an average of this number of cases and deaths occurred daily for four months, with the outbreak continuing at a lower level for about a year.

The experience of the authors, members of the "Joint Dysentery Unit," a cooperative activity involving military and civilian organizations, including the Florida State Board of Health, led them to conclude: Epidemics of dysentery encountered in the Armed Forces may be of unprecedented size, the clinical and laboratory features may be atypical, and the opportunities for study may be unexcelled. There are simple though essential requirements for the handling of these major problems. For effective action, prompt reporting is as essential in military as in civilian practice. Consultative assistance in the clinical, laboratory and epidemiologic field may be required. A mobile laboratory may be essential for the highly important early studies of a major epidemic. Their experience in Korea directs attention to the value of the commissions of the Armed

Forces Epidemiological Board; a more frequent use of this available assistance in the field may be recommended. Certainly this study demonstrates how widely enteric infections encountered in the Armed Forces abroad may differ from those encountered at home.

Chronic Brucellosis, Recent Advances in Diagnosis and Treatment. By Lydia Allen DeVilbiss, M.D. J. Am. M. Women's A. 7:326-330 (Sept.) 1952.

The worldwide importance of brucellosis, as emphasized by the World Health Organization, is stressed in this paper. Methods of transmission, the author states, include the discovery that brucellosis is an air-borne infection; organisms will penetrate mucous membranes of the eyes, the respiratory and intestinal tracts, and will infect through the unbroken skin .

The characteristics of active chronic brucellosis and their similarity to those of tuberculosis are described. Also, methods of diagnosis, laboratory procedures and treatment are outlined. Twelve brucellosis research institutes in a worldwide distribution, where batteries of scientists are searching for improved methods of prevention, diagnosis and treatment, are mentioned as most hopeful features for the control of brucellosis, acute and chronic.

Pelvioprostatic Venography: Preliminary Report. By Raymond J. Fitzpatrick and Louis M. Orr. J. Urol. 68:647-651 (Sept.) 1952.

The authors present a preliminary report of the results of the injection of radiopaque materials into the deep dorsal vein in living subjects. In 5 cases they made pelvioprostatic venograms in an attempt to evaluate the usefulness of the procedure from the clinical standpoint. They conclude that it is difficult to be certain at the present time of the value of this procedure from the standpoint of adding further information to the diagnostic armamentarium. Until a sufficiently large number of pelvioprostatic venograms is obtained to established the normal pattern, the departure from the normal cannot be appreciated. They plan future studies to ascertain whether or not there is change of pattern of the vessels in cases of prostatic carcinoma with extension beyond the capsule and to test other uses of the procedure which immediately suggest themselves.

Surgical Considerations in Removal of Renal and Ureteral Calculi, with Special Emphasis on Removal of Staghorn Calculi. By S. Joseph Pearlman, M.D. Am. J. Surg. 84:302-305 (Sept.) 1952.

In view of the present widespread use of extensive nephrotomy in cases of staghorn calculosis, the author re-emphasizes some of the undesirable aspects of this operation and presents certain experiences with more conservative maneuvers which have yielded more satisfactory results. He discusses general principles to be observed in the removal of renal and ureteral calculi, and their importance to the prevention of recurrences. His preference is for the use of ureterolithotomy and pelviolithotomy, and even for ureterolitholapaxy, rather than extensive pole-to-pole nephrotomy, and he recommends more widespread use of direct roentgenologic control at the time of operation to reduce the incidence of "false" recurrences.

Syphilitic Optic Nerve Atrophy Treated with Penicillin: Observations Two to Six Years After Treatment. By Curtis D. Benton, Jr., M.D., and J. Frank Harris, M.D. A.M.A. Arch. Ophth. 48:449-454 (Oct.) 1952.

The results of this study indicate that penicillin is effective in arresting the early stages of atrophy of the optic nerve. Twenty-three patients with progressive syphilitic primary atrophy of this nerve were treated with one course of penicillin and observed for an average of four years after therapy.

There was satisfactory arrest of visual loss in all of the 7 patients whose initial visual acuity was 20/50 or better. In these cases the effective dose of penicillin was 4,800,000 to 6,000,000 units. All but 3 of the 16 patients whose vision was worse than 20/50 failed to retain their same vision, despite treatment with 6,000,000 to 18,000,000 units of penicillin. This critical level of pretreatment vision is apparently of prognostic significance, the authors conclude, and corresponds closely to the figure of 20/60 given by Moore as an important factor in predicting the outcome of malaria therapy.

It is noteworthy that when diminution of vision progressed, it usually did so within one and one-half years. It remains to be determined whether larger doses of penicillin alone or combined with fever will be beneficial to patients with moderate or severe visual damage.

Cutaneous Papillomatosis, Pseudo-Acanthosis Nigricans, and Benign Acanthosis Nigricans. By Morris Waisman, M.D. South. M. J. 46:162-169 (Feb.) 1953.

Review and comparison of *papillomatose confluente et réticulée* and pseudo-acanthosis nigricans lead the author to conclude that these two dermatoses are identical diseases, and he prefers the name pseudo-acanthosis nigricans. Occurring in obese and brunette persons and resembling acanthosis nigricans except for the reticulated configuration on the trunk, the disease is provoked by perspiration, maceration and friction, and it may disappear after reduction of weight.

Benign acanthosis nigricans, a genetically transmitted nevoid disturbance of the skin, is morphologically indistinguishable from the malignant form of acanthosis nigricans which is invariably accompanied by internal cancer. Clinically, pseudoacanthosis nigricans can be differentiated from acanthosis nigricans chiefly by the absence of a reticulated pattern of lesions in the latter. Whether a distinction can be made histopathologically is as yet inconclusive.

Since the sites on which lesions of pseudo-acanthosis nigricans localize are also those commonly affected by miliaria and intertrigo, it is suggested that in some way the activity of sweat glands may play a part. Diminution or absence of sweating over affected areas has been recorded, and decrease or absence of sweat glands is an almost constant histopathologic observation. It is conjectured that a variety of external influences, physical, chemical, and actinic, may lead to reversible papillomatous changes in the skin. The tendency to attribute the dermatosis of benign acanthosis nigricans and the associated obesity and dermatosis of pseudo-acanthosis nigricans to endocrine disease is unsupported by clinical and laboratory proof.

The Early Recognition and Treatment of Bronchogenic Carcinoma. By Jack Reiss, M.D., F.C.C.P., George L. Baum, M.D., and Maurice Kovnat, M.D. Dis. of Chest 22:529-538 (Nov.) 1952.

Since most patients with bronchogenic carcinoma reach the surgeon in an inoperable state, the authors stress the importance of recognizing the disease in the "silent phase." In this stage of bronchial cancer, the tumor may be evident but symptoms are not yet present. Pneumonectomy at this point should give far better results than are now obtained. They therefore stress the need for mass survey films.

In the series of 70 consecutive cases of bronchogenic carcinoma analyzed, only 20 were deemed operable. At operation, in but 10 of the 20 was the tumor resectable; of these 10, in only 5 had the patient survived for an average of 17 months from the earliest clinical manifestations of the disease. In 19 cases there was coexistent chronic pulmonary disease. During the period in which the 70 patients with bronchogenic carcinoma were admitted, only 23 with gastric carcinoma were similarly hospitalized. Seven illustrative cases are reviewed.

It is proposed that all adult members of the population have roentgenograms of the chest at six month intervals and that each survey film be inspected by two competent physicians, one of whom should be a qualified radiologist. The conclusion is that despite diagnostic advances, sole reliance on accepted principles of symptomatology and investigative technic causes the immediate goal of saving the lives of the majority of patients with this condition to fall far short of attainment.

Sexual Precocity: Case Report. By Richard G. Skinner, Jr., M.D. South. M. J. 46:194-195 (Feb.) 1953.

Sexual precocity, a relatively uncommon disorder, is classified by Wilkins as of four types: (1) neurogenic; (2) idiopathic activation of pituitary; (3) gonadal; and (4) adrenal. Dr. Skinner presents the case of a 7 year old white boy as an example of the type due to the idiopathic activation of the pituitary.

This case was regarded as one of the so-called constitutional type of sexual precocity because of the normal ketosteroid findings. If the precocity had been due to an adrenal tumor, the ketosteroid excretion should have been much higher, perhaps 15 to 30 mg. The presence of symmetrically enlarged testicles would tend to eliminate gonadal tumors, such as an interstitial cell tumor or teratoma. This also helped to rule out adrenal tumors, in which cases one usually finds infantile testicles. Lack of history of previous illnesses would tend to rule out encephalitis. Normal neurologic examination and roentgenograms of the skull helped in eliminating brain tumors.

An Introduction to the Problem of the Alcoholic. By Leonard L. Weil, M.D. South. M. J. 46:189-190 (Feb.) 1953.

The problem of alcoholism is approached from the standpoint of etiologic factors creating the situation, the treatment of acute alcoholic intoxication, and the treatment of withdrawal symptoms or the hangover. The reasons for drinking, as stated by the patients, are described as endogenous and exogenous and are discussed together with various theories. The present scientific approach to therapy is reviewed, including the conditioned-reflex-aversion method, which, regardless of how utilized, should be combined with psychotherapy, a psychologic survey, and sociologic adjustment. The therapeutic measures employed in the treatment of the hangover are described as limited only by the number of hangovers and all unsatisfactory.

Since the ever-increasing number of alcoholic addicts usually seek the aid of the family physician, the problem of alcohol addiction singularly falls in the realm of general practice. Emphasis is placed upon the responsibility resting upon the general practitioner. He has need to evaluate ever more carefully the problems of humanity for "it is his understanding of human frailty, his sympathy for his fellow man, his understanding of the problems that beset the species homo sapiens, that make his shoulders broad enough to sustain him who cannot sustain himself."

Trichomonas Vaginalis Donne: An Evaluation of Experimental and Clinical Data. By Carl Henry Davis, M.D., and C. G. Grand, M.D. Am. J. Obst. & Gynec. 64:544-551 (Sept.) 1952.

Regarding Trichomonas vaginalis as a possible contributing factor, through chronic irritation, in the development of cancer of the cervix uteri, the authors report a comparative study of slides in New York and Miami indicating that fewer women have a T. vaginalis infection in the latter area. They summarize experimental data and clinical observations and comment upon the ease of diagnosis. In discussing the problems of treatment, they observe that many of the numerous types of therapy tested have effected cures in 80 to 90 per cent of cases within a few weeks or months. While no drug has proved to be specific, practically all of the antiseptics in common use readily kill the T. vaginalis. It is their observation that vaginal preparations containing aureomycin hydrochloride, recently recommended by some clinicians, have not provided a higher percentage of apparent cures than may be obtained by other available preparations and that the severe yeast infection which may follow the use of this antibiotic may be more difficult to cure than that caused by T. vaginalis.

Today there is better understanding of the nature of infection with this organism and greater appreciation of the need for daily treatments over a variable period of time. Also, newer pharmaceuticals have facilitated the necessary home treatments. Nevertheless, it is concluded that probably just as high a percentage of cures may be obtained by the use of ichthyoglycerine tampons and medicated douches at home, containing older drugs such as mercury bichloride, formalin, liquor cresolis, tincture of green soap, potassium permanganate, or iodine in appropriate strengths. Also, silver nitrate commonly has been used in office practice. All of these, with the possible exception of ichthyol, have been demonstrated to be among the most effective trichomonacides.

The Henry Approach to Femoral Hernia. By Harry C. Hull, M.D., and Joseph B. Ganey, M.D. Ann. Surg. 137:57-60 (Jan.) 1953.

The anterior, low midline extraperitoneal approach as described by Arnold K. Henry in 1936 is advocated for the repair of femoral hernias. The technic is described. A series of 16 cases is reported with case reports of 2 fatal cases.

The authors favor this approach for several reasons. It allows an excellent and easy approach to unilateral or bilateral femoral hernias through one incision. Their elective repair can be made in conjunction with other abdominal and pelvic operative procedures. If an anomalous obturator artery is present, it is readily discernible and can be avoided, or, if necessary, safely ligated. Cooper's ligament is accurately defined and the obliteration of the femoral canal can be made with this ligament or pectineal fascia as snugly as desired without danger to the iliac vein, which is at all times under direct vision.

Also, the hernial sac and contents can be released by incising the lacunar and/or inguinal ligaments under direct vision. Abundant access to a wide area of parietal peritoneum is obtained so that complete inspection and necessary definitive surgery can be performed with ease. The use of this approach in the obese patient is, however, not advised.

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Giving Versus Receiving

The rewards for attention to a medical practice in these days are all too often measured in terms of money and financial security. While it is true that we are engaged in the practice of a profession or business, for which we are recompensed to a greater or lesser degree, and that the possession of some money is necessary if we are to continue to practice our profession and carry on our businesses, there are other compensations which are not measurable by conventional standards. But these other compensations, arising in the course of a medical practice, depend on the exercise and demonstration of those qualities which endeared the old time family physician to his patients and friends. The time just to talk, the hearty handclasp, the cheering word, the friendly smile, the outpouring of friendship, characterized the family physician of yesteryear.

You cannot receive to the fullest extent unless at the same time you are giving to the extent of your capacity. If this is a selfish concept, it is still fundamental. People are and will be interested in you to the same degree in which you are interested in them, and manifest that interest to them. It has been said that the esteem of the physician is no longer what it was, and that his stature has diminished in the eyes of the public. It is strange, is it not, that the advances in surgical and medical skill, new technics, new drugs, innumerable new discoveries and advancing knowledge of disease have not counteracted this tendency to loss of professional prestige in the eyes of those we serve? If this is so, it has been of our own choosing. There is more to the practice of medicine than surgical skill, knowledge of new drugs and how to use them, advanced methods of diagnosis and improved methods of administering treatment, and the introduction of modern business methods and practices in the doctor's office and in the hospital and clinic.

We possess, just as our forefathers in medicine possessed, those characteristics which endeared them to their patients. We can share of our personality, as they did of theirs, manifesting a wholesome interest in the affairs of the individual, the locality in which we live, our state and nation, contributing generously and enthusiastically to the well-being of those with whom we come in contact, sharing with them our enthusiasm for medicine, our confidence in America and its institutions. We have much to share. Let us be generous while we can.

Frederick K. Herpel

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Abstract Department

Kenneth A. Morris, M.D., Chairman Jacksonville
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Outlook for Polio Protection

There is probably no subject today on which the physician is more frequently interrogated than that of poliomyelitis. At this writing the quest for adequate protective measures against this crippling disease has turned the nation's eyes hopefully on Montgomery County, Alabama, where a mass polio inoculation project with gamma globulin is under way.

In a final report evaluating gamma globulin as a prophylactic agent for poliomyelitis, Hammon and his associates[1] concluded that in extensive field tests on numerous children gamma globulin in an average dose of 0.14 cc. per pound of body weight conferred highly significant protection against paralytic poliomyelitis for a short period of time. They emphasized that gamma globulin is no panacea for the prevention of the paralytic form of polio, pointed out its drawbacks and disadvantages as well as its advantages, and stressed that it should be given intramuscularly, never intravenously, and with a separate heat-sterilized syringe and needle for each child. This report merits the physician's careful perusal.

For the present and immediate future, it appears that gamma globulin from blood is the only means of protection, aside from that "touch of polio" which is either not noticed in children or recognized only as a slight feverish upset, but is effective enough to cause polio antibodies to be formed. The future, however, gives promise of an effective, safe vaccine from such sources as monkey kidneys and fertile hen's eggs.

Salk and his associates[2] recently reported studies in human subjects inoculated with different experimental poliomyelitis vaccines. For the preparation of these vaccines virus of each of the three immunologic types was produced in cultures of monkey testicular tissue or monkey kidney tissue. Prior to inoculation of human subjects, the virus was rendered noninfectious for the monkey by treatment with formaldehyde. In one series of experiments antibody for all three immunologic types appeared to be induced by the inoculation of small quantities of such vaccines incorporated in a water-in-oil emulsion. In other experiments, intradermal inoculation of aqueous vaccines containing the type 2 virus induced formation of antibodies which persisted without signs of decline for four and a half months, the longest interval studied. It was concluded that it should be possible with a noninfectious preparation to approximate the immunologic effect induced by the disease process itself.

These encouraging results point to a new source of protective vaccine, the supply problem for which can be solved. One pharmaceutical

manufacturer plans to make the vaccine available immediately after it has passed all tests for safety and effectiveness. He thinks the cost will not be prohibitive, even with monkeys at $45 to $50 apiece already arranged for from India, because of the good yield of virus for vaccine from the tissues of the monkey kidney.

Fertile hen's eggs are under investigation as a new and readily available source of supply in the field of poliomyelitis virus cultivation. For those authorities who believe that a killed virus never gives as lasting protection as a live one, this source has particular appeal. Cox and his associates[3] have grown the polio virus on fertile hen's eggs, and tests show that the virus is truly modified, causing formation of protective antibodies but not causing polio. They were able, however, at last reports to get only one strain of one type of polio virus to grow on this medium, while all three types will grow on monkey kidney and are included in the vaccine developed by Salk and his associates.[2] The egg vaccine not only solves the supply problem, but it has the additional advantage of being given by mouth. No injection is necessary, and in Dr. Cox's opinion the route of administration is advantageous because it follows the natural way the polio virus enters the body, through the mouth and the digestive tract.

These tests offer encouragement in the fight against polio which may mean another triumph for medicine is at hand. Meanwhile, the research data presented on gamma globulin should help the practicing physician to use the material in the most effective manner and aid him in keeping such records as will be of greatest value in the search for more knowledge about the effective use of gamma globulin.

1. Hammon, W. McD.; Coriell, L. L.; Wehrle, P. F., and Stokes, J., Jr.: Evaluation of Red Cross Gamma Globulin as a Prophylactic Agent for Poliomyelitis: 4. Final Report of Results Based on Clinical Diagnosis, J. A. M. A. 151: 1272-1285 (April 11) 1953.
2. Salk, J. E., and others: Studies in Human Subjects on Active Immunization Against Poliomyelitis: 1. A Preliminary Report of Experiments in Progress, J. A. M. A. 151:1081-1098 (March 28) 1953.
3. Blood '53 Anti-Polio Hope, Science News Letter 63:230 (April 11) 1953.

1953 Medical District Meetings

"A", Tallahassee	October 19
"B", St. Augustine	October 20
"C", Tampa	October 21
"D", West Palm Beach	October 22

Body Appreciation

There are music appreciation classes and literature appreciation classes. Why not body appreciation classes? The idea seems constructive. Every doctor-patient interview might well become such a class, to the benefit of patient and physician alike.

Physicians as well as patients are prone to take the body for granted. That veritable treasure house grows commonplace as patient after patient drones on, reciting trivial or imaginary or easily avoided ills. But really serious ailments come as sharp reminders that humanity is fearfully and wonderfully wrought. From a physical standpoint, each one of us is a marvelous creature. If that fact were more fully appreciated and the body treated with more respect and consideration, the harassed physician would have more time to devote to combating serious diseases and would find the practice of medicine more stimulating. In the interest of body appreciation, he might impress upon his patients how richly endowed they are. He might say:

Take the very hairs of your head, for example. You doubt that they are numbered? Ask the Federal Bureau of Investigation. There you can be identified by one single hair, an unmistakable mark of your individuality, made for you alone.

Where do you find perfection in cameras? They are standard operating equipment right in your own head, set for a lifetime of service if given reasonable care. Two of them, just to make sure, adjust to light and dark, take pictures in black and white and in full colors, even in full motion, and develop them instantaneously. These miniature cameras which are your eyes are such wonderful bits of creative genius that they enable you, without changing the lens, to look at yourself or the stars in the heavens innumerable light years away.

The ears, two again for good measure, are minute sensory organs, really private, personal radios, which solve difficult problems of mechanics and organize a complex variety of air waves into meaningful patterns. Their performance is truly awe-inspiring. Yet how often their protection is neglected, especially by the swimmer.

Is the skin just a covering to hold you in, or is it a remarkable sensory organ whose highly refined sensitivity is a most precious possession? Surely many of you delight to abuse it in the Florida sun.

Think how poverty-stricken you would be if your brain were any less versatile. For example, take the gift of memory, of reasoning, of judgment, of ability to solve problems. Perhaps the greatest abuse of the brain is failure to develop its potential capabilities.

What a collection of factories the body has to furnish nourishment, repair and growth. The bellows that keeps the oxygen flowing makes of your lungs a complete blood-purifying factory. The factories of the alimentary tract convert raw material into nutritive elements. The sugar factory in your mouth, the chemical plant which is your stomach, the intestinal workshop, all carry on their complicated tasks of selection, assimilation and waste disposal, no matter how much or how often you insult them. The kidneys and other glandular bodies also carry on their intricate functioning as they secrete and stop secreting according to some master plan. And where is the electronic system which can compare in performance to your nervious system?

Skeleton? Who wants a skeleton? But what a sight you would be without one. The one you have is exceedingly durable, withstands shock, and even repairs itself from within. It gives you protection where you need it without hampering action. Nevertheless, sheer carelessness on your part takes an excessive toll in fractures.

All these rich and highly individual endowments, including not only the power of repair but also that of reproduction, are of no avail without that faithful little pump which keeps your blood circulating from before birth even until death. It is estimated that your heart will beat 800 million times if yours is a normal life span. This one pound muscle does an amazing amount of pumping just to keep you going a single day. Yet you not only take your heart for granted, but you keep disease of this organ in the forefront of causes of death by thoughtlessly and persistently abusing it.

So, "Have a heart," as the saying goes. Take up body appreciation as a new interest and reap untold benefits.

That goes for you, too, Doctor. You are quite as marvelous a creature as is your patient.

The Editor Invites Your Contributions on

Data of Notable Interest

World Medical Association Important to All Physicians

What the World Medical Association is and what it stands for are matters of moment to every physician. Too often it is confused with the World Health Organization, which is a branch of the United Nations, representing the governments of the world in the field of health and supported entirely by government funds. The World Medical Association, on the other hand, is an organization of national medical associations, composed of one from each of the participating nations which is most representative of the medical profession of that country. The American Medical Association is the American member. Thus this international body represents the practicing profession of the world and is supported entirely by dues and voluntary contributions.

Why should the average doctor have any interest in this organization? "First of all," says Dr. Louis H. Bauer, secretary-general of the World Medical Association and immediate past president of the American Medical Association, "an increasing number of problems relating to health and medicine are being discussed and decided on an international level. Most of the bodies discussing these problems have one viewpoint only, and that is the viewpoint of government. Without the World Medical Association, there is no one to present the opinions of practicing physicians. Their views should be heard and considered, but they cannot give them as individuals. Their voice can be heard only through an organization. The World Medical Association, through its 43 member associations, can speak for 700,000 physicians. I believe all will agree that this is a voice that should not be ignored. Furthermore, what happens in other countries is sooner or later likely to affect us here. Therefore, we should work with our colleagues in other countries and attempt to solve the problems facing the profession.

"Six years of experience with doctors of other nations has shown me conclusively that the same problems face the profession in all countries. They differ only in degree. That, perhaps, is not surprising. What is surprising is that doctors all over the world think alike about these problems, differing only as to details."[1]

Out of his wide experience with physicians abroad, Dr. Bauer has often emphasized how fortunate this country is that government has not

made the inroads on the practice of medicine that it has in many other countries. He points out that one way to keep medical practice free is to cooperate with other countries and fight the encroachments of socialism by the international route. In this respect, the contribution of the World Medical Association alone in exposing the machinations of the International Labor Organization[2] should command the support of the physicians of this country. Sponsorship of the First World Conference on Medical Education, held in London last April, is another great contribution of the World Medical Association to the welfare of medicine. Additional examples of its importance are its studies of the medical aspects of social security, standards of hospitals and development of an international code of medical ethics, its stand on an international pharmacopeia, and its continuing battle to protect the rights and privileges of doctors in both peace and war.

Supporting committees have been established in some countries in which individual membership is possible. In the United States, the World Medical Association, United States Committee, Inc., is a nonprofit organization which medical societies, business organizations and individuals may join. Members receive the association's publications, which keep them abreast of medical news of the world; they may attend the general assemblies of the association as official observers; and they may receive letters of introduction facilitating visits to medical centers in other countries.

The ability of the World Medical Association to speak for the practicing profession is its greatest function. It too often happens that the profession is ignored when matters of moment to both the profession and the public are decided. Here is an effective voice in international medical affairs, long greatly needed. And here is a great opportunity for all doctors to help make the World Medical Association a powerful influence in molding world opinion about medicine.

1. The President's Page, J. A. M. A. 151:1494 (April 25) 1953.
2. The Bricker Resolution, editorial, J. Florida M. A. 39:766-767 (April) 1953; ILO — Danger Ahead! editorial, ibid. 39:278 (Oct.) 1952.

First Global Conference on Medical Education

A history-making medical conference on a global basis will take place this month. The First World Conference on Medical Education will be held at the British Medical Association House in London, August 22-29. Among the 600 physicians attending from all over the world will be representatives from practically all of the 72 approved medical schools in the United States.

Sponsoring the conference is the World Medical Association, which has a membership of national medical associations from 43 countries. Cooperating agencies are the World Health Organization, the Council of International Organization of Medical Sciences, and the International Association of Universities.

Practicing physicians from most of the countries of the world will have an opportunity at this meeting to state how medical education has met or failed their needs. The entire subject will be reassessed in the light of present day advances in medical science, and a free exchange of ideas will be encouraged throughout the conference.

Many of the physicians attending from this country will go on to The Hague for the Seventh General Assembly of the World Medical Association, scheduled for August 31 through September 7.

DOCTOR, ARE YOU MOVING?

Keep The Journal advised as to your current address.

University Honors Doctors

At its Centennial commencement on June 8, 1953, the University of Florida signally honored four Florida physicians. Upon Drs. William C. Thomas, Sr., of Gainesville, Walter C. Payne, Sr., of Pensacola, Turner Z. Cason of Jacksonville and Warren W. Quillian of Coral Gables it conferred the honorary degree of Doctor of Science. All of these distinguished physicians of the state have long been prominently identified with the Florida Medical Association, and Drs. Thomas and Payne are past presidents. Their activities in promoting numerous aspects of public health and medical education and their constructive approach to medical problems have made Florida a better state in which to live.

Dr. Thomas, beloved citizen of the University community, was honored for his contributions to medical science at home and abroad and for his unselfish devotion to the highest traditions of the medical profession which have elevated him to a place of leadership among the medical practitioners of Florida.

Recognized as a consecrated practitioner of a noble profession for more than 40 years, Dr. Payne was honored for his labors both as a physician and developer of hospitals and health services in the state, a contribution matched by a record of public service in other fields involving human welfare.

Native son of the University city, Dr. Cason was honored as an indefatigable advocate of medical education and adequate health services for the people of Florida and for his unceasing efforts, now crowned with success, to develop a great medical center at the University, where the youth of Florida may learn the healing arts.

Dr. Quillian was accorded recognition as a specialist in pediatrics, medical administrator and friend of children and was honored for contributions to the alleviation of human suffering so numerous and outstanding as to merit the praise and gratitude of his adopted state.

Doctors labor much more diligently in the public interest than the public realizes. The man



Left to right, Drs. Walter C. Thomas, Sr., Warren W. Quillian, Walter C. Payne, Sr., and Turner Z. Cason.

in the street would doubtless be astonished to learn the extent to which they freely give of themselves in professional services rendered without compensation and in time spent without remuneration in the interest of the public weal. If these services could be valued accurately, we doubt not that some critics of the medical profession would be truly astonied — probably to the point of incredulity.

It is, therefore, particularly heartening when a great state institution elects to honor physicians for especially meritorious service. Such gracious acts redound to the good of the profession as a whole and enhance its prestige in the public eye.

A. M. A. Annual Meeting in New York

In characteristic fashion, New York City extended its famed hospitality to the members of the American Medical Association and their guests who in record numbers attended the 102nd annual meeting of that organization there the first week in June. The magnitude of the convention is reflected in the official total registration of 48,980, including guests and exhibitors, the largest in the association's history and doubtless a world record for a medical meeting. This figure, broken down to 17,958 physicians, 24,186 residents, interns, technicians, students, nurses and physicians' guests, and 6,836 exhibitors and their guests, is in sharp contrast to an attendance of 573 when the association first met in New York City exactly a century ago. Some 5,000 more physicians were in attendance than when the annual convention was last held there in 1940.

More than 400 papers were presented before the 21 scientific sections on clinical and experimental studies, reports of surveys, reports of new drugs and technics. An innovation was presentation for the first time of medical colored television projected on two large screens, the telecasts of clinics previously having been received on several small screens. There were panel discussions of the diseases involved before the operations began, and the diseases presented were mitral stenosis, cancer of the cervix, peptic ulcer, tumor of the breast, and sinusitis. In addition, more than 6,000 persons viewed a variety of medical motion pictures presented twice daily, often with the authors themselves present to discuss their own films.

More than a thousand physicians and scientists gave voluntarily of their time and energy to demonstrate 260 scientific exhibits, in which emphasis was placed on aspects of medicine of particular interest to the general practitioner. A special attraction was the exhibit based on a survey of 400 general practitioners showing the instruments and drugs considered most essential for a doctor's bag to enable him to handle almost any emergency. The scientific exhibits occupied the entire fourth floor of the Grand Central Palace, and on the first three floors 370 technical exhibits were arranged with some 2,000 persons assigned to answer questions about drugs, surgical and diagnostic instruments, appliances, and many other products. Here was a vast "medical merchandise mart" displaying innumerable new items from which physicians could select those most helpful in their daily practice.

The House of Delegates, meeting at the Waldorf-Astoria Hotel, took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of other subjects which ranged from public relations to medical education.

Among the distinguished personalities particularly in the limelight were the incoming President, Dr. Edward J. McCormick of Toledo, Ohio, and Dr. Walter B. Martin, President-Elect. A Virginian by birth, Dr. Martin has a brilliant record of service to medicine during the 35 years he has devoted to the practice of internal medicine in Norfolk in his native state. Highlighting the recent progress in heart surgery was the award of the Distinguished Service Medal of the American Medical Association to Georgia-born Dr. Alfred Blalock of Baltimore. A pioneer in cardiac surgery, this internationally famous Southerner received the association's highest scientific honor for his outstanding work in vascular surgery, especially for his part in the development of the "blue baby operation," which has saved the lives of hundreds of infants with congenital pulmonary stenosis.

Featured entertainment was provided by the Doctors' Symphony Orchestra of New York, which received particular acclaim. Another highlight was the presentation of a citation to Jean Hersholt, the familiar "Dr. Christian," for his portrayal of the family doctor.

The immensity and complexity of the meeting, featuring a notable scientific program, important policy actions, exhibits, television shows, motion pictures, radio broadcasts, fraternity meetings and alumni reunions, made a profound impression on the nearly 49,000 physicians and

guests in attendance. Physicians at work and at play presented a unique display even for New York.

This year's Clinical Session will be held in St. Louis, and the next annual meeting will go to San Francisco. Florida will welcome the 1954 Clinical Session for Miami has been selected as the host city.

Registration

Total registration of Association members at the 1953 annual meeting in New York was 129. Members in attendance were:

BRADENTION: Lowrie W. Blake. CLEARWATER: John T. Karaphillis. COCOA: Thomas C. Kenaston. CORAL GABLES: Jack Q. Cleveland, C. Howard McDevitt, Jr., Frederick P. Poppe, Louis C. Skinner, Jr., Hillard W. Willis. DANIA: Fred E. Brammer. DAYTONA BEACH: John J. Cheleden. DELRAY BEACH: James R. Nieder. FORT LAUDERDALE: Norris M. Beasley, Russell B. Carson, Alfred E. Cronkite, Burns A. Dobbins, Jr., Richard A. Mills. FORT MYERS: Joseph D. Brown, Harry Fagan, Jr. GAINESVILLE: Alva T. Cobb, Jr., William C. Thomas, Jr. HIALEAH: Eli Galitz. HOLLYWOOD: Dale T. Anstine, William J. Gallo, Maxwell M. Hartman, Royle B. Klinkenberg, Bernard Milloff, Randall W. Snow. JACKSONVILLE: Jackson L. Allgood, Jr., William H. Brooks, Joseph A. J. Farrington, Leonard Garten, Gordon H. Ira, Samuel S. Lombardo, Bernard J. McCloskey, Robert B. McIver, Jerome H. Newman. KISSIMMEE: John O. Rao. LAKELAND: John E. Daughtrey, David S. Kenet. LAKE WORTH: Carl M. Pults. MIAMI: Lawrence Adler, Ernest R. Barnett, Gail E. Chandler, Reuben B. Chrisman, Jr., Carl H. Davis, M. Jay Flipse, Samuel Gertman, Herman Glassman, James J. Griffitts, Winston F. Harrison, Ella M. Hediger, Carlos P. Lamar, John J. McAndrew, Wayne B. Martin, Isidore Marx, Leon H. Mims, Jr., E. Sterling Nichol, Colquitt Pearson, Homer L. Pearson, Jr., Irwin Perlmutter, William C. Phillips, Edwin P. Preston, Hunter B. Rogers, Wiley M. Sams, George F. Schmitt, Jr., Robert T. Spicer, Donald G. Stannus, Richard F. Stover, Herbert W. Virgin, Jr. MIAMI BEACH: Bernhard Baer, Max Dobrin, I. Leo Fishbein, Abraham R. Hollender, Valentine E. Jenkins, Saul H. Kaplan, Harold S. Kaufman, Leo M. Levin, Alexander Libow, David S. Light, Meyer B. Marks, Saul Miller, Julius R. Pearson, Francis A. Reed, Maurice J. Rose, Jack A. Rudolph, Jandon Schwarz, Benjamin L. Steinberg, Nicholas A. Tierney. MILTON: John W. Reece. NAPLES: James A. Craig, John J. Meli. OCALA: William H. Anderson, Jr., Carl S. Lytle. ORLANDO: Benjamin L. Brock, Solomon D. Klotz, John G. Marsh, Pleasant L. Moon, Louis M. Orr, II. PALM BEACH: Fred E. Manulis, Joseph R. West. PENSACOLA: Herbert L. Bryans. QUINCY: George H. Massey. ST. AUGUSTINE: Vernon A. Lockwood. ST. PETERSBURG: Arnold S. Anderson, Arthur Appleyard, Jr., James K. McCorkle, Norval M. Marr, Richard H. Sinden. SARASOTA: John M. Butcher, Joseph Halton, Melvin M. Simmons. SEBRING: Leldon W. Martin, Zaven M. Seron. TAMPA: Frank S. Adamo, Harold O. Brown, Joshua C. Dickinson, Gaetano C. Ferrante, Nathan L. Marcus, Alfonso F. Massaro, Anthony P. Perzia, Burdette Smith, Harold Sutker, Wesley W. Wilson. VERO BEACH: John P. Gifford, James C. Robertson. WEST PALM BEACH: Harry E. Bierley, Theodore Norley, Ralph M. Overstreet, Jr. WINTER HAVEN: Henry F. Keiber.

Graduate Medical Education

The Seminar on Gastroenterology presented by the Department of Medicine of the Graduate School of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health, was held at the George Washington Hotel in Jacksonville, June 18-20, inclusive.

Dr. H. Marvin Pollard, Professor of Internal Medicine at the University of Michigan, delivered the lectures on Thursday and Friday, and with the assistance of Dr. James L. Borland held a clinic and question period Saturday morning. The patients presented at the clinic provided clinical material illustrative of the lectures delivered the two previous days. This practical demonstration aided in stimulating many pertinent questions, both regarding the patients and the points brought out by Dr. Pollard. He was practical and lucid in the manner of presenting his subjects and at the same time brought postgraduate gastroenterology up to date for his listeners.

The Twenty-First Graduate Short Course for doctors of medicine was presented to the physicians of Florida at the George Washington Hotel in Jacksonville the week of June 22-27. Each subject was ably handled by the individual specialist.

This year's course was notable for the fact that each lecture carried with it information which the physicians in attendance were glad to receive. This appreciation was manifested by their interest throughout the whole course. Each course was presented by a well known teacher in his particular field of medicine. The excellency of the method of teaching was evidenced at each lecture.

The total registration for both the Gastroenterology Seminar and the Short Course was 212, a lamentably poor attendance when the facts are considered. The Committee on Medical Postgraduate Course met Wednesday, June 24, and will meet again in the fall to consider plans for graduate medical education in 1953-1954. It is highly probable that radical changes will be made next year in the methods of presenting what has been known in the past as the Graduate Short Course. This Graduate Short Course was designed for the general practitioner, and this idea has dominated the thinking in all the planning during the past 21 years. Apparently the lack of interest on the part of the general practitioner does not justify a continuation of this type of planning even though all graduate medical education presented under the auspices of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health is accredited and accepted by the American Academy of General Practice. Suggestions offered prior to the October meeting of the Committee will be welcomed and given serious consideration.

STATE BOARD OF HEALTH

Maternal and Child Death Rates — 1952

Members of the medical profession and public health personnel concerned with maternal health are to be commended for the large drop in maternal mortality in this state during 1952.

Analysis of the preliminary data on maternal deaths for 1952 shows that the maternal death rate decreased from the previous low record of 12.1 maternal deaths per 10,000 live births in 1951 to a new low of 7.7 in 1952. This represents a decrease of 36 per cent since the preceding year. The rates for both white persons and Negroes showed about the same percentage of change.

Table 1 compares the 1952 preliminary data with 1951 data. It is noted that the rate for Negroes of 16.4 is almost four times as high as the rate of 4.3 for white persons.

Table 1.—Comparison of 1952 Preliminary Data with Data for 1951

Race	Maternal Deaths		Death Rate*	
	1952	1951	1952	1951
Total	57	85	7.7	12.1
White	23	35	4.3	7.0
Negro	34	50	16.4	25.1

*Deaths per ten thousand live births.

A comparison of maternal mortality for Florida and the United States indicates that the Florida maternal death rate for 1952 is a little higher than the national average. When rates for two separate geographical locations are compared, however, a compensation should be made

Table 2.—Recorded Maternal Deaths by Cause of Death and Race, Florida, 1951 and 1952

Cause of Death	Total		White		Negro	
	1952	1951	1952	1951	1952	1951
Total all causes	57	85	23	35	34	50
Sepsis of pregnancy	0	0	0	0	0	0
Sepsis of childbirth and puerperium	7	15	3	8	4	7
Toxemia of pregnancy	13	24	2	5	11	19
Toxemia of the puerperium	7	2	4	1	3	1
Hemorrhage of pregnancy	0	1	0	0	0	1
Hemorrhage of childbirth	6	13	2	7	4	6
Abortion without sepsis or toxemia	3	1	0	0	3	1
Abortion with sepsis	3	7	2	2	1	5
Ectopic pregnancy	2	9	0	4	2	5
Other complications of pregnancy, childbirth and the puerperium	16	13	10	8	6	5

for the difference in proportion of nonwhite births. When the Florida maternal death rate is adjusted to compare with the national figure, it turns out to be 6.1, or exactly the same as that for the United States. It is hoped that for future years the Florida rate will be lower than the national average.

Table 2 indicates the number of maternal deaths according to cause for the years 1951 and 1952. The largest decreases were noted in sepsis of childbirth and puerperium, toxemia of pregnancy, hemorrhage of childbirth, and ectopic pregnancy.

While great strides were made in reducing maternal deaths, the infant death rate rose. From table 3 it can be seen that the rise was primarily due to an increase in the deaths of Negro infants.

Table 3.—Comparison of 1952 Preliminary Data with Data for 1951

	Infant Deaths		Death Rate	
Race	1952	1951	1952	1951
White	1399	1362	26.2	27.0
Negro	1149	967	55.6	48.4
Total	2548	2329	34.4	33.1

The following comments concerning Negro infant deaths give some indication of where future efforts should be placed. Largest increases were in the diseases listed:

Cause	1952	1951
Postnatal asphyxia and atelectasis	148	89
Pneumonia	171	134
Nutritional maladjustment	29	18
Ill-defined diseases of early infancy	58	47
Gastritis, duodenitis, enteritis and colitis	79	69
Congenital malformations	63	55

Deaths from infections and parasitic diseases dropped from 52 to 37.

Deaths from postnatal asphyxia and atelectasis were predominantly in the group under 4 days of age.

Deaths from pneumonia were predominantly between the ages of 14 days and 9 months.

Infant mortality rates increased in 44 counties.

All age groups under 9 months of age showed an increase in death rates with the greatest increase in those under 1 month.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Sanford Levine of Miami Beach announce the birth of a son, Herbert Neal, on May 16, 1953.

Dr. and Mrs. Edward E. Cava of Miami announce the birth of a daughter, Anita Ada, on May 26, 1953.

Dr. and Mrs. Frank L. Fort of Jacksonville announce the birth of a daughter, Mildred Leslie, on June 11, 1953.

Dr. and Mrs. David B. Manley of Orlando announce the birth of a son, David Bott III, on June 19, 1953.

Marriages

Dr. Harry Kaufman of Miami Beach and Miss Francine Abigail Sontag of Kew Gardens, N. Y., were married on June 13, 1953.

Dr. Bernard S. Kleinman of Miami Beach and Miss Helen Ratkay of Chicago were married on June 14, 1953.

Deaths — Members

Smith, H. Mason, Tampa ..... June 16, 1953

Deaths — Other Doctors

Futch, T. Allen, Jr., Thomasville, Ga.... ....March 20, 1953
Gonzalez, Aurelio A., Tampa ..... June 13, 1953

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Lacy, George E., Miami
Lansman, Wilfred, Miami Beach
McDermid, Howard C., Okeechobee

Medical Officers Returned

Dr. Thomas W. Meldrum, who entered military service on July 1, 1951, was released from active duty on April 16, 1953 with the rank of lieutenant (U.S.N.). His address is 8630 Lem Turner Road, Jacksonville.

STATE NEWS ITEMS

Dr. Sherman B. Forbes of Tampa attended the annual meeting of the American Ophthalmological Society in Hot Springs, Va., the last week in May.

Dr. Raymond J. Fitzpatrick announces the opening of his office at 926 S. W. 2nd Avenue, Gainesville, for the practice of urology.

Dr. Walter H. Winchester of Dunedin entered medical service with the U. S. Navy on May 31, 1953 with the rank of lieutenant.

Dr. Douglas R. Murphy of Venice entered medical service with the U. S. Navy on May 1, 1953 with the rank of lieutenant.

Dr. Joseph D. Foley of Jacksonville entered military service on May 4, 1953 as a captain in the Air Force.

Dr. Terry Bird of Apalachicola recently visited the Association's headquarters office.

Dr. Meredith Mallory, Sr., of Orlando, member of the Board of Governors, was a recent visitor to the Association's headquarters office.

Dr. J. Basil Hall of Tavares recently addressed the Kiwanis Club of Groveland. He spoke on the subject of individual health and prolonging the life span.

Dr. Richard C. Cumming of Ocala was recently re-elected president of the Marion Players of that city.

Dr. Herbert L. Bryans of Pensacola recently addressed the Hospital Trustee Institute at Panama City. His subject was "Trustees and the Medical Staff."

Dr. Jack H. Bowen of Jacksonville took a week's course at the Skin and Cancer Hospital in New York City in May.

Dr. Carl J. Larsen of Avon Park recently addressed the Rotary Club of that city. His subject was "Killer Disease."

Dr. Peritz Scheinberg of Miami recently addressed the Dade County Chiropody Society.

Dr. Charles R. Wiley has opened offices for medical practice in Englewood.

Dr. James N. Patterson of Tampa was installed as president of the Florida Association of Blood Banks at the recent meeting of the Association in Tampa. Dr. John T. Stage of Jacksonville was elected president-elect of the Association. Other officers installed included Dr. James M. McClamroch, Gainesville, vice president, and Dr. Sherman B. Forbes, Tampa, secretary.

Dr. Louis M. Orr, II, of Orlando was elected a member of the Council on Medical Service succeeding Dr. James Q. Graves of Monroe, La., at the recent meeting of the American Medical Association in New York City. The term runs until 1958. Dr. Orr also served as a member of the A. M. A. House of Delegates reference committee on Insurance and Medical Service.

Dr. Edward J. Clark of Callahan was a recent guest speaker at a meeting of the Forest-Dale Woman's Club of Jacksonville. He showed the film, "Self-Examination for Cancer," and conducted a question and answer period.

Dr. Thomas M. Palmer of Jacksonville attended a reunion of Rhodes Scholars in England in June.

Dr. Richard G. Skinner, Jr., of Jacksonville recently attended a Seminar on Rehabilitation of the Handicapped Child held under the auspices of the New York University Medical School, Bellevue Hospital.

The late Dr. Henry B. Cordes of Frostproof was recently honored by the Frostproof Garden Club, who chose Decoration Day for the planting of the Dr. Cordes memorial tree, a mahogany tree.

Dr. Grace C. Hardy of Jacksonville spoke on "Interdependence of Nations" at the Coronation Luncheon given by the Daughters of the British Empire recently. Dr. Hardy attended the Children's Conference in Miami in April. This Conference was sponsored by the Dade County Pediatric Society, the Nemours Foundation and the Florida Crippled Children's Society.

Dr. Bernard A. Kaminski of Miami Springs entered medical service with the U. S. Air Force on Nov. 8, 1952 with the rank of captain.

Dr. Morris A. Price of Jacksonville spoke at the Ramona Boulevard School summer roundup in May.

Dr. James F. Speers of Titusville was a recent guest speaker at a meeting of the Titusville Kiwanis Club.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

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COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Society has announced the beginning of a transcribed radio program on station WBRD, Fort Lauderdale. Dr. Thomas L. Roberts, Jr., of Fort Lauderdale, chairman of the Society's Committee on Public Relations, is in charge.

Dade

The regular monthly meeting of the Dade County Medical Association was held on July 7. Following adjournment of the business meeting, there was a general discussion of medical economics problems.

Franklin-Gulf

The Franklin-Gulf County Medical Society met on June 3 at Beacon Hill.

Lake

Dr. Wilbur Davis of Orlando was guest speaker at the meeting of the Lake County Medical Society on June 3. His subject was "Some Problems in Oral Surgery."

At the July meeting of the Society, Dr. Newton C. McCollough of Orlando spoke on "Bursitis."

Marion

The Marion County Medical Society has paid 100 per cent of its state dues for 1953.

Orange

Drs. Francisco A. Hernandez, Ralph Edwards and Milton S. Saslaw of Miami were guest speakers at the meeting of the Orange County Medical Society on May 20. Dr. Hernandez spoke on "Catheterization in Congenital Heart Disease;" Dr. Edwards spoke on a "Children's Cardiac Clinic;" and Dr. Saslaw spoke on "The Rheumatic Problem in Florida."

Palm Beach

The Palm Beach County Medical Society in conjunction with the State Board of Health is sponsoring free tests for diabetes.

Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1953.

OBITUARIES

George A. Paulk

Dr. George A. Paulk died at his home in Coral Gables on Feb. 9, 1953, after a lengthy illness following surgery performed several years previously for carcinoma of the prostate. He was 76 years of age. Burial took place in his native town of Alapaha, Ga.

Dr. Paulk was born in Alapaha on Feb. 25, 1876. Following graduation from high school he went directly to the University of Louisville School of Medicine. On receiving his medical degree, he spent some time with the doctors of his community until he reached the age of 21, the minimum age required for the practice of medicine in the state of Georgia. Here, as is the custom with the country doctor, he took a most active part in community and business affairs. He was the organizer and president of the Alapaha Bank, in which capacity he served until coming to Miami in 1926. Subsequently, he moved to the larger neighboring town of Tifton where he continued in the general practice of medicine, which included surgery of the kitchen table variety.

In Tifton, Dr. Paulk continued to serve his community and state. He served in the Georgia Legislature first as Representative in the House in 1913-1914 and again as Senator from 1915-1916. In 1924-1925 he was Chief Industrial Commissioner and at various times served as chairman of numerous committees, namely of State Sanatoria, of Agricultural Commission, of Banks and Banking, of Education, of Hygiene, of Penitentiary Committee, of Rules Committee, of Western and Atlanta Railroad Committee, of University of Georgia Committee and of the Temperance Committee.

Before coming to Miami in 1926, Dr. Paulk became interested in Eye, Ear, Nose and Throat and took postgraduate work at Grady Hospital, New Orleans and a final six months' course at Polyclinic in New York. In Miami he associated himself in the practice of his chosen specialty with his brother-in-law, the late Dr. Austin Kemp. Following Dr. Kemp's death, he associated himself with the E. J. Hall Clinic of Miami. Here he continued to practice until several months before his death, during which time he was the oldest physician, in point of active practice, in Dade County. While during the last ten years Dr. Paulk's practice was confined to a full schedule of office work, he was at one time on the staff of Victoria Hospital and Jackson Memorial Hospital.

Dr. Paulk was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was a member of the Phi Chi medical fraternity and also a Mason and a Shriner.

Besides his widow, the former Doris Kemp, he leaves a son, George A. Paulk, Jr., of New York City, and two daughters, Mrs. W. I. Burt of Cleveland and Mrs. John Behney of Miami.

Luke Harvey Bartee

Dr. Luke Harvey Bartee of Port St. Joe died at the Municipal Hospital in that city on Feb. 16, 1953 after a long illness. He was 81 years of age. Interment took place in Magnolia Cemetery at Apalachicola.

Dr. Bartee the son of James Allen and Julia Ann Thornton Bartee, was born at Roxanna, Ala., on April 3, 1872. Early in his life his parents moved to Georgia, settling on a plantation in Meriwether County near Woodbury. Upon finishing his high school education there, he entered the University of Georgia School of Medicine at Augusta. In 1899 he was awarded the degree of Doctor of Medicine by that institution. He was licensed to practice medicine in Georgia that same year, and was licensed in Florida in 1905.

In 1920, Dr. Bartee located in Port St. Joe, where he continued in the general practice of medicine for 33 years. A devout Christian gentleman, he was a member of the First Baptist Church and taught the Men's Bible Class there for a long time. He was a member of the Masonic Lodge, both in Georgia and Florida.

Dr. Bartee was for some years a member of the Franklin-Gulf County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association.

(Continued on page 128)

Clinical Results* with Banthine® Bromide

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22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Meili	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossetf, Knox Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week.
10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

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(Continued from page 126)

Survivors include the widow, Mrs. Esther Childers Bartee of Port St. Joe; one son, Edward Harvey Bartee, and one daughter, Mrs. Mae Bartee Dutton, both of Mobile; five sisters, Mrs. W. S. Sims and Mrs. J. L. Edwards of Manchester, Ga., Mrs. B. B. Lovett and Mrs. Rachel Sheppard of Woodbury, Ga., and Mrs. J. S. McGuffin of Jacksonville; and one brother, J. M. Bartee of St. Petersburg. Three grandchildren also survive.

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Walter Eugene Wilkins

Dr. Walter Eugene Wilkins of Jacksonville died suddenly at his home on March 2, 1953. He was 49 years of age. Funeral services and interment took place in Mars Hill, N. C.

The son of Walter and Sallie Bailey Wilkins, Dr. Wilkins was born on July 9, 1903, in Columbia, S. C. He received his academic training at Furman University and the University of North Carolina. In 1933 he was awarded the Ph.D. degree in biology and chemistry by Vanderbilt University, and in 1938 the School of Medicine of that institution conferred upon him the M.D. degree. From 1929 to 1936 he was an instructor at Vanderbilt, and in 1938-1939 served an internship in pediatrics at Vanderbilt Hospital. He then continued his training at Willard Parker Hospital in New York City during 1939.

Throughout the decade of the forties Dr. Wilkins engaged in public health activities. He served as director of the division of school health of the North Carolina State Board of Health from 1939 to 1942; medical nutrition officer of the War Food Administration in Washington from 1942 to 1945; senior surgeon (res.), United States Public Health Service, in charge of the nutrition section in 1945; and director of nutrition investigations and services in the Florida State Board of Health from July 1946 until he resigned in 1950. At that time he entered the private practice of medicine in Jacksonville.



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Dr. Wilkins was a member of the Duval County Medical Society, the Florida Medical Association and the American Medical Association. Since 1940 he had been a member of the governing council of the American School Health Association, serving as its president in 1946-1947. He was also a member of Phi Beta Pi and Alpha Omega Alpha.

His contributions to medical and scientific journals were numerous. He was the inventor of the cup needle for taking blood samples for laboratory tests.

Surviving are the widow, Mrs. Katherine Gibbs Wilkins of Jacksonville; two daughters, Mrs. Erik Tranoy of Oslo, Norway, and Miss Ann Kierulff Wilkins of Jacksonville; his mother, Mrs. Sallie B. Wilkins of Long Beach, Calif.; one brother, Dr. Franklin B. Wilkins of Whittier, Calif.; one sister, Mrs. Louise Leiby of Long Beach, Calif.; and an uncle, Col. F. N. K. Bailey of Sebring.

(Continued on page 130)

Cook County Graduate School of Medicine

POSTGRADUATE COURSES — 1953

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting September 14, September 28, October 12. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting October 26. Surgical Anatomy & Clinical Surgery, Two Weeks, starting August 17, November 9. Gallbladder Surgery, Ten Hours, starting October 26. General Surgery, One Week, starting October 5. Surgery of Colon & Rectum, One Week, starting September 21. Basic Principles in General Surgery, Two Weeks, starting September 21. Thoracic Surgery, One Week, starting October 12. Esophageal Surgery, One Week, starting October 19. Breast & Thyroid Surgery, One Week, starting October 26. Fractures & Traumatic Surgery, Two Weeks, starting October 26.

GYNECOLOGY—Intensive Course, Two Weeks, starting September 21. Vaginal Approach to Pelvic Surgery, One Week, starting August 31.

OBSTETRICS—Intensive Course, Two Weeks, starting October 5.

DERMATOLOGY—Intensive Course, Two Weeks, starting October 19.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting October 12. Intensive General Course, Two Weeks, starting September 28. Gastroenterology, Two Weeks, starting October 26. Allergy, One Month and Six Months, by appointment.

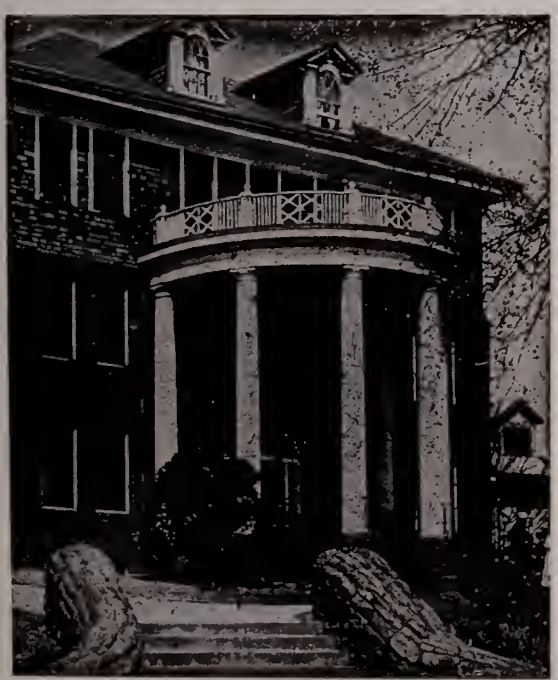
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Associate Medical Director

(Continued from page 129)

Thomas Joseph Moore

Dr. Thomas Joseph Moore of St. Petersburg died at Duke Hospital in Durham. N. C., on Feb. 21, 1953, after an illness of several months. He was 32 years of age. Funeral services and interment were in Elmira, N. Y.

A native of New York, Dr. Moore was born in Elmira and attended school there. He received the degree of Doctor of Medicine in 1945 from Duke University School of Medicine. After serving an internship at New York Post-Graduate Hospital, he entered military service in 1946 and was subsequently discharged at Bolling Field Station Hospital.

Dr. Moore had engaged in general practice in the St. Petersburg area for two years. His offices were at Madeira Beach, and he resided at Redington Beach. He was a staff member at both Mound Park and St. Anthony's hospitals in St. Petersburg.

A member of the Pinellas County Medical





Society. Dr. Moore had held membership in the Florida Medical Association since 1951. He was also a member of the American Medical Association.

He is survived by his widow, Mrs. Nancy Spangler Moore, and one daughter, Catherine Dale Moore, of Redington Beach; and his mother, Mrs. D. B. Moore of Bronxville, N. Y.

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From where I sit *by* Joe Marsh

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No wonder Handy made a big impression on the ladies. What they didn't know—till the show's end—was that Buck Mulligan was hiding behind the backdrop improving on Handy's aim with a hatpin.

From where I sit, we all get things "put over" on us now and again. When it's good-natured—fine! But, some folks would fool us into believing it's wrong to enjoy a glass of beer. Others would tell their neighbor how to practice his profession. For real American tolerance and neighborliness these people are simply "off target."

Joe Marsh

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Current Affairs is Your Affair

In pursuit of my favorite topic, education, I want to talk about Study Group, especially in Medical Auxiliaries. Study Group anywhere is valuable, but nowhere does self-improvement benefit so many as in medical circles. The simple reason is that the doctor and his family have been and will continue to be a target of interest as well as suspicion.

This singular position was brought about by an avalanche of adverse propaganda, conceived by politically active men who opposed the existing medical system and wished to replace it with a system foreign to our way of life. The ensuing battle has left its mark. The very victory we achieved through education, in itself, makes us more vulnerable, for in proclaiming that we have preserved an American way of life, we have given the people a right to expect us to understand and defend it.

We resisted a national law which by its passage in Congress would have deprived the American doctor of freedom in medical enterprise in accordance with the Constitution of his Association. We could not have done that without knowing why it was important to the medical profession as well as to the country. Nor could we have known without concerted study of the issues involved. We had to know in order to care

and we had to care in order to educate those who did not know or care, and by so doing we improved ourselves and preserved a precious freedom.

To do less when our nation's freedom is in danger of being legislated away is to lock one's self in a center room of a house which is catching fire.

For instance, in the April issue of The Journal, an editorial, "The Bricker Resolution," quotes another editorial entitled, "ILO — Danger Ahead!" It "pointed out that this nation is now under greater threat of socialism by treaty than by domestic legislation and urged widest recognition of the possibility of political and economic regimentation from external sources. It cited a treaty adopted last June by the ILO embodying socialized medicine, which requires only a two-thirds vote of the Senate for ratification, making it a law of the land regardless of the will of the people." Is this possible? What is the Bricker Resolution? How does it affect you? What is the ILO? How does it function? Does treaty agreement have precedence over national law? What are the external sources which threaten?

These questions and many more could be explained and understood with an active Study Group in an Auxiliary. It would make the doctor's wife a leading and constructive force in the community in which she so frequently takes an active part.

Before women became organized and earned the right to vote, it was not as dangerous for us to be ill-informed, but in an age when the voting potential of women can admittedly wreck a nation by voting its liberties out of existence, a greater obligation rests upon us to stress thinking in our groups.

When we stop to remember the number of bills we have been asked to endorse in various organizations to which we belong and remember the manner and method employed to achieve unanimous endorsement, it might be wise to consider the importance of thinking out a subject before we speak on it and to understand a resolution before we vote upon it.

Mrs. C. Robert DeArmas

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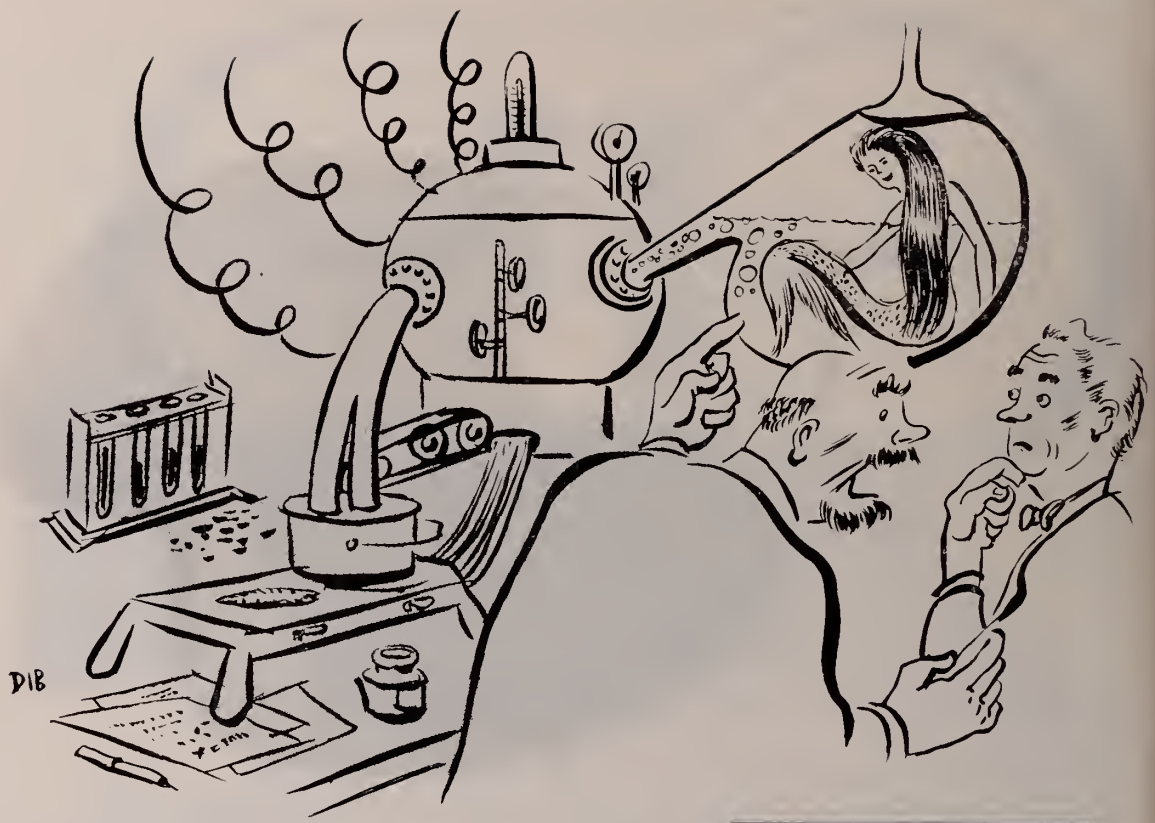
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
da Medical Districts	John D. Milton, Miami	Council Chairman	
Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, Oct. 19, '53
Northeast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, Oct. 20, '53
Southwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, Oct. 21, '53
Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, Oct. 22, '53
da Specialty Societies			
emy of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
gy Society	James H. Putman, Miami	Lewis Palay, Miami Beach	" "
thesiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
ter, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
th Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
strial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
nd Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
hal. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
opedic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Oct., '53
ologists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
tric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	
ologic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	Hollywood, Apr. 25, '54
ological Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
gical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 7, '53
od Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	
ue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
ue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	Jacksonville, May '54
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
nical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
ntal Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
art Association	Jere W. Annis, Lakeland	William P. Hixon, Pensacola	
spital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
edical Examining Board	Ralph B. Spires, DeFuniak Springs	Homer L. Pearson, Jr., Miami	
edical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
rses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
armaceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
blic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, Oct. 22-24, '53
udeau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
berculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	
man's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers, Jr., Cocoa	Hollywood, Apr. 25-27, '54
ican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
hern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, Oct. 26-29, '53
ama Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
gia, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
Hospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
heastern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
heastern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
heastern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53



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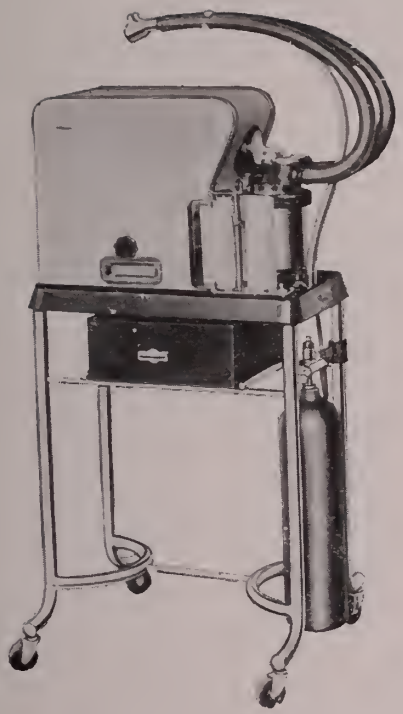
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	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	22	A-1-54 Francis M. Watson, M.D. Marianna
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	91	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	100%	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	14	10	A-2-55 George S. Palmer, M.D., Tallahassee
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	60	55	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	100%	252
C	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	44	42	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Duval *Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	258	228	
	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	27	100%	
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	100%	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
D	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	25	24	B-4-55 Thomas C. Kenaston, M.D., Cocoa
	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	29	28	
	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	172	169	
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	75	692
C	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	176	169	C-5-55 Clyde O. Anderson, M.D., St. Petersburg
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	20	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	205	202	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	44	
D	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	24	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	94	615
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	123	100%	
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	17	16	
E	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	96	95	D-8-55 Russell B. Carson, M.D. Fort Lauderdale
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	631	566	
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Vol. XL SEPTEMBER, 1953 No. 3

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Pheochromocytoma
M. Eugene Flipse

Use of Insulin in Diabetes
H. Phillip Hampton

Hyaluronidase, Cortisone, Stress and Bacteria and Protective Urinary Colloids
Arthur J. Butt, Joseph Seifter and Ernst A. Hauser

Carcinoid Tumor of Rectum
Edward Jelks and Donald M. Christoffers

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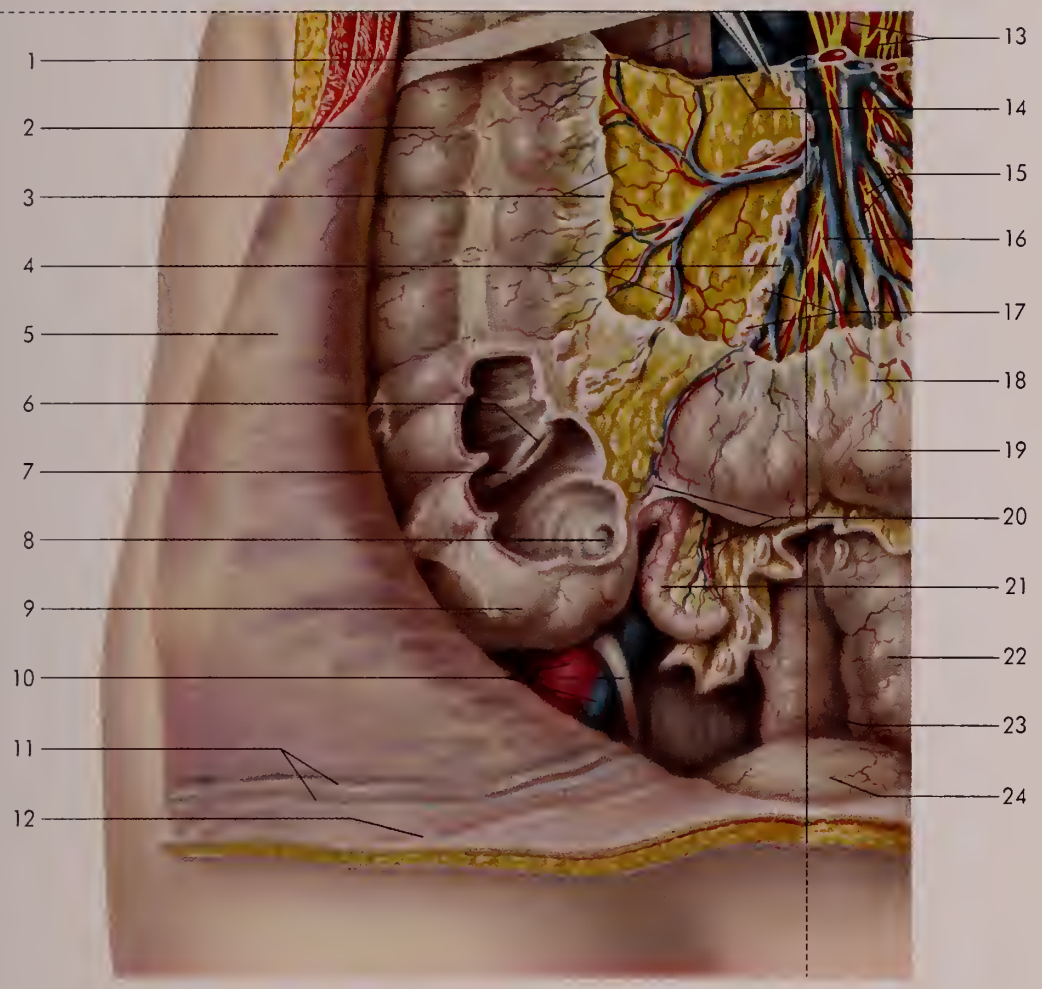
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2 Ascending colon
3 Mesocolon
4 Branches of ileocolic artery and vein
5 Parietal peritoneum
6 Ileocecal valve
7 Frenum
8 Appendicocecal valve
9 Cecum
10 Ureter and external iliac artery and vein
11 Epigastric artery and vein
12 Lateral umbilical ligament
13 Aorta and abdominal aortic plexus
14 Vena cava
15 Intestinal arteries and veins
16 Sympathetic abdominal plexus
17 Ileocecal lymph nodes
18 Mesentery
19 Ileum
20 Ileocecal fold and appendicular artery and vein
21 Vermiform appendix
22 Sigmoid colon
23 Rectum
24 Urinary bladder

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Meat...

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Although caloric needs in the later decades of life lessen with decreasing physical activity and diminishing metabolic rate, clinical observations[1] corroborated by experimental studies[2] show that protein needs of the aging organism continue at the levels of adequacy in earlier years.[3] For avoidance of protein deficiencies, which the aged are prone to develop,[4] the protein quota of the diet of persons over fifty should be more liberal than is often the practice.[5] In providing this quota, lean meat may well be one of the protein foods of the daily diet.

In the years beyond fifty, as well as before, continuous adequate protein nutrition remains an absolute necessity for maintenance of a normal concentration of plasma proteins and, in turn, a normal osmotic pressure of the plasma.[6] Even more pronounced in the aged than in younger persons are the ill consequences of hypoproteinemia—edema, decreased resistance to generalized infection, retarded bone healing, and poor wound healing.[7] Furthermore, dietary protein is essential for the continuous chemical regeneration of cell protein in the prevention of abnormal tissue wasting, one of the most characteristic and obvious changes in the geriatric patient.[8]

But meat is much more than an outstanding protective protein food in the dietary of persons over fifty. It also supplies generous amounts of the B group of vitamins and of iron, phosphorus, and other essential minerals. In the well-balanced diet of the later years of life, meat is just as important for the maintenance of nutritional and physiologic well-being as it is during the earlier years of life.

REFERENCES

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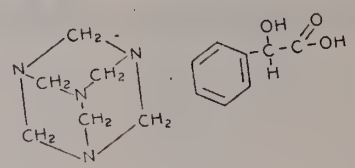
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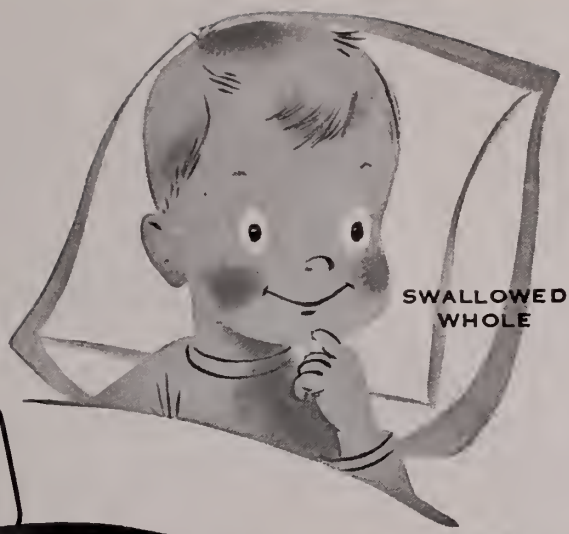
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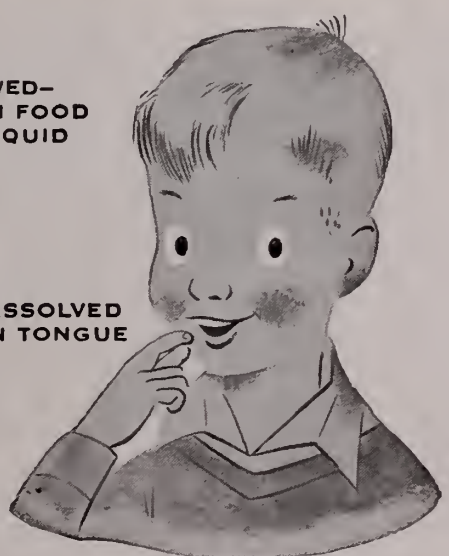
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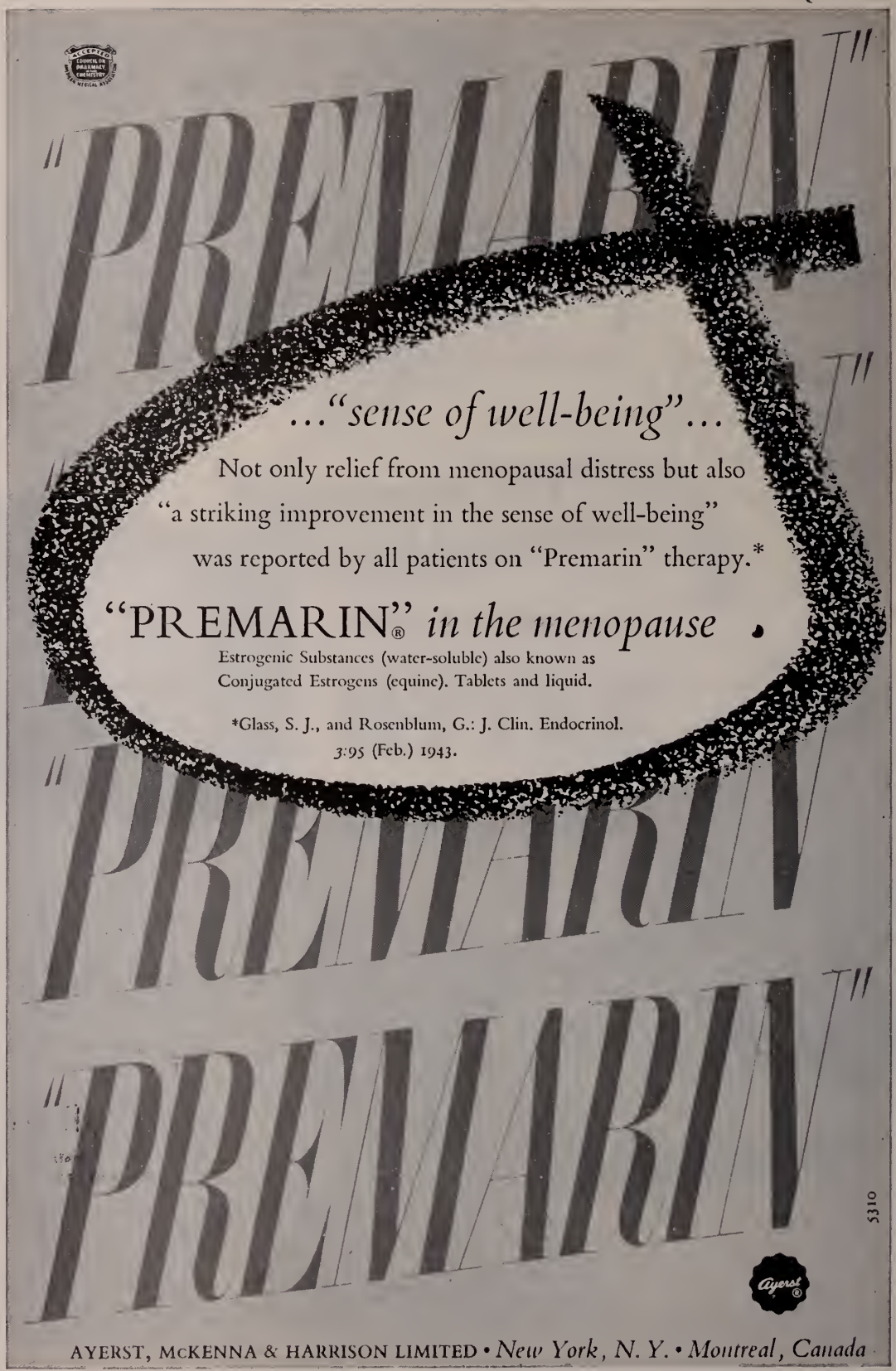
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*Glass, S. J., and Rosenblum, G.: J. Clin. Endocrinol.
3:95 (Feb.) 1943.
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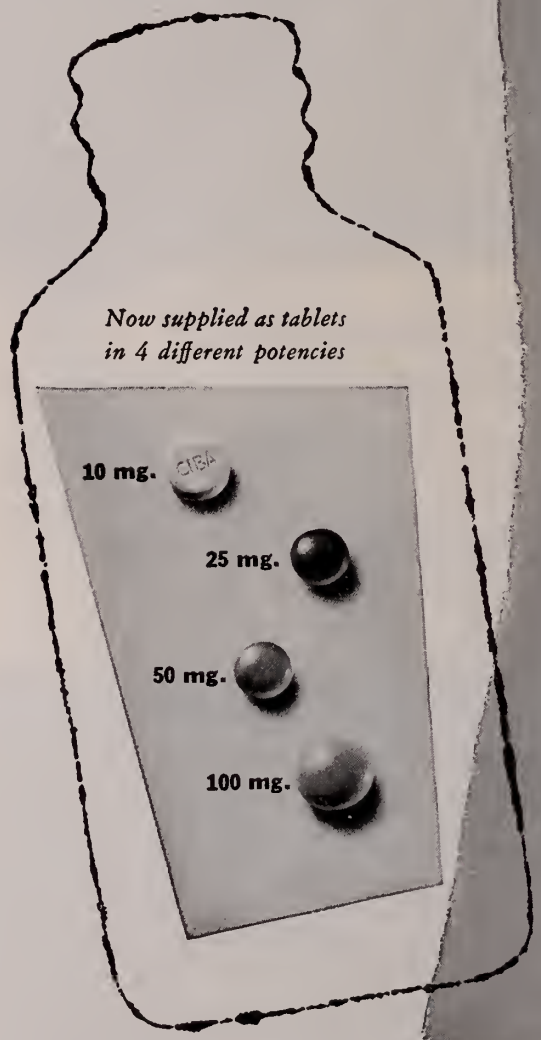
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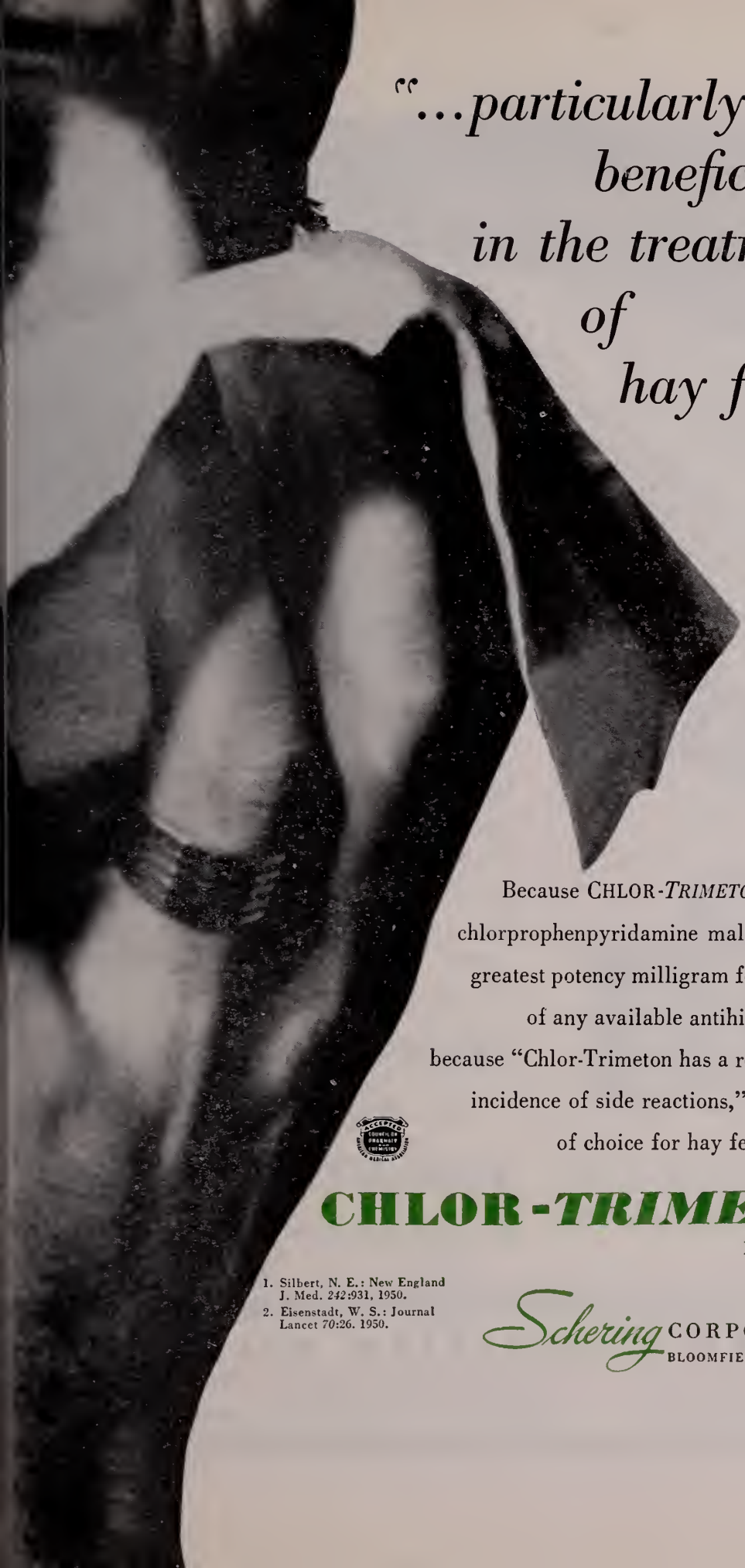
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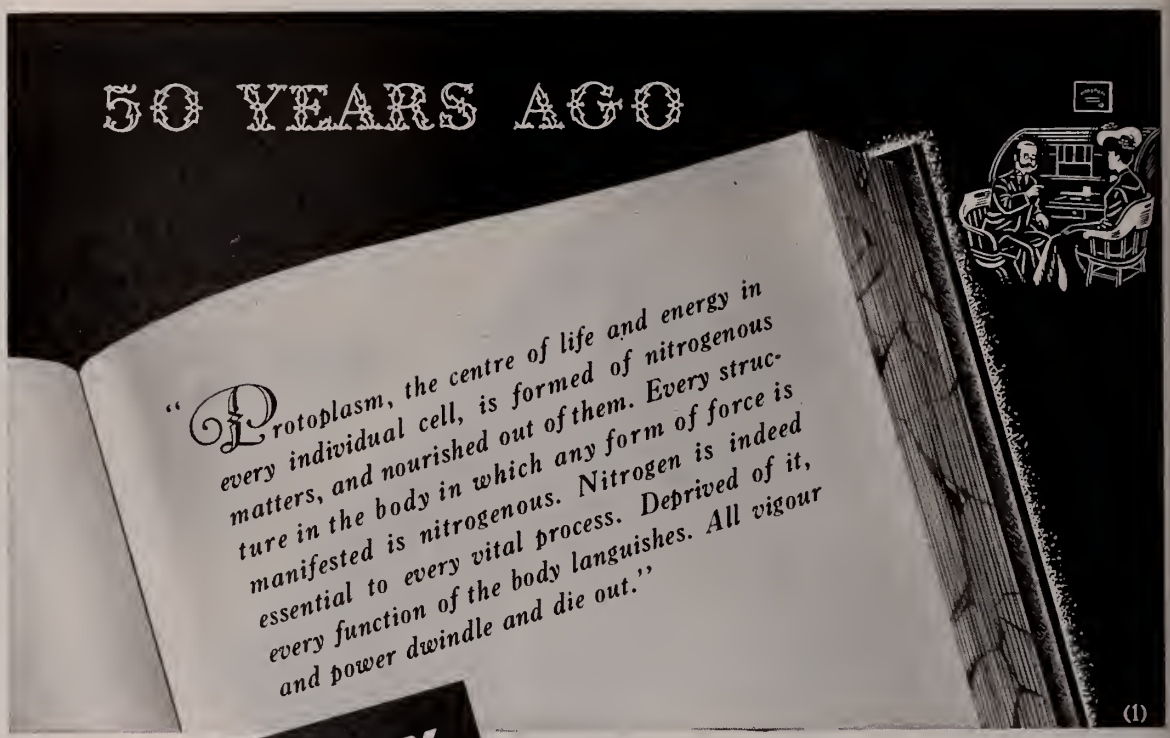
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(1) Cheadle — *Artificial Feeding and Food Disorders of Infants*, Sixth Edition, (1906)
(2) National Research Council—*Recammended Dietary Allowances*, Reprint 129, (1949)

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XL Jacksonville, Florida, September, 1953 No. 3

Pheochromocytoma

M. Eugene Flipse, M.D.
MIAMI

Interest in the physiologically active tumors of chromaffin tissue is currently high because of the improved technics for their diagnosis and management. These tumors, the pheochromocytomas of the adrenal medulla and the paragangliomas of the sympathetic nervous system, are usually designated collectively as pheochromocytomas. They are as a rule histologically benign but physiologically malignant because of their continuous or intermittent secretion of excess amounts of epinephrine (adrenalin) and norepinephrine (arterenol). Although clinical experience, diagnostic acumen and a high index of suspicion might lead one to believe that a clinical problem could be explained on the basis of the hemodynamic and metabolic effects of these pressor amines, proof usually depends upon the results of various pharmacologic tests.

Paroxysmal Hypertension

The best known manifestation of pheochromocytoma is the adrenal sympathetic syndrome which is caused by the sudden outpouring of epinephrine and norepinephrine. It is characterized by a sudden rapid rise in blood pressure associated with tachycardia, great anxiety, headache, pallor particularly of the face, numbness, tingling and coldness of the hands and feet, sometimes nausea and vomiting, and pain in the epigastrium or substernal areas, usually followed by excessive perspiration. This syndrome rarely may occur in the absence of pheochromocytoma as a result of a centrally initiated generalized discharge of the sympathoadrenal system in patients with either an overwhelming anxiety state or neoplasms in the hypothalamic region.

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 27, 1953.

Clinical diagnosis of the intermittently functioning pheochromocytoma would be relatively easy if the complete adrenal sympathetic syndrome were usually present, but atypical, incomplete syndromes predominate. Not infrequently the chief symptoms are localized, rather than generalized, suggesting a single system disorder rather than one produced by a humoral mechanism. Thus headaches, vertigo, blindness, aphasia, loss of consciousness, or convulsions might suggest migraine, histamine cephalgia, brain tumor, epilepsy or cerebral vascular accident; hypertension, palpitation, tachycardia, substernal pain, pulmonary edema or cardiac arrhythmias might suggest primary cardiac disease; and nausea, vomiting and abdominal pain might suggest tabetic crisis, peptic ulcer or other intra-abdominal disease.

Difficulty may arise in the evaluation of patients who ultimately prove to have anxiety states, hysteria or cardiac neurosis, or who are in menopause, particularly if they have an unrelated sustained or paroxysmal hypertension, for these patients frequently describe a wide variety of attacks or spells often having some features in common with the adrenal sympathetic syndrome. Neuropsychiatric evaluation may be advisable in this group, for patients with pheochromocytoma have been incorrectly classified as neurotics, and yet neurotics may have a pheochromocytoma. Surgical exploration should probably never be resorted to in these neurotic patients unless there is first an unequivocally positive response to one of the pharmacologic tests, for numerous explorations giving negative results have been carried out in this type of patient on the basis of the clinical features even though the reactions to all pharmacologic tests were negative.

Finally it must be remembered that there may be great fluctuation in the blood pressure of patients with essential hypertension, nephritis, eclampsia and the diencephalic hypertension described by Page.

Sustained Hypertension

It has recently been emphasized that pheochromocytomas may produce a clinical picture indistinguishable from that of either benign or malignant essential hypertension.[1] Since the hypertensive-cardiovascular disease of pheochromocytoma can usually be completely cured by the surgical removal of the tumor, every patient with sustained hypertension should be screened for this condition by means of pharmacologic tests.

If the routine testing of all patients with sustained hypertension is not considered feasible, certainly all patients who have hypertension of any magnitude or who show evidence of vascular damage in the retina, brain, heart or kidneys or who are to be subjected to the hazards and/or inconveniences of surgical, dietary or newer drug therapy, should be screened for pheochromocytoma. Furthermore, since the first manifestation of these tumors may be a sudden hypertensive crisis followed by collapse and even death during the induction of anesthesia or the performance of even minor surgery, their presence should be excluded before one undertakes nonemergency surgery in any hypertensive patient.

The possibility of finding a pheochromocytoma is significantly increased in patients having hypertension associated with a wide variety of other conditions such as vasomotor attacks, excessive perspiration, low grade fever, glycosuria and/or hyperglycemia, the neurocutaneous syndromes[2] of multiple neurofibromatosis (von Recklinghausen's disease) or multiple hemangioblastoma (von Hippel-Lindau disease) and especially hypermetabolism without hyperthyroidism as evidenced by an elevated basal metabolic rate with normal serum levels of protein-bound iodine and/or normal radioactive iodine uptake by the thyroid gland.

Unfortunately many patients with sustained hypertension due to pheochromocytoma present nothing clinically to suggest the diagnosis. All hypertensive patients, therefore, should be screened by pharmacologic tests.

Pharmacologic Tests

Since actual chemical and biologic assays of blood and urine for increased amounts of epinephrine and norepinephrine are as yet not practicable, the pharmacologic tests for pheochromocytoma are indirect tests. These indirect tests are divided into two groups, the provocative or pressor tests and the blocking or depressor tests.

Since the interpretation of all of the tests in both groups depends nearly completely upon observed changes in blood pressure, every effort should be made to insure absolute accuracy of the blood pressure readings and to eliminate the sometimes profound effects of extrinsic influences upon the blood pressure and its response to various stimuli. All medications which might influence the cardiovascular system and its reactions, either directly or indirectly through peripheral or central action, should be omitted for a sufficiently long period to insure their complete elimination from the body. Others have emphasized that all narcotics and sedatives should be avoided for at least 24 hours preceding the tests and that after potassium thiocyanate therapy the tests should be deferred until the serum levels of the drug have fallen to the level for normals in the particular laboratory.[3,4] It is probable that the newer hypotensive agents, hexamethonium, apresoline® and the hydrogenated ergot derivatives as well as a program of rigid sodium restriction could interfere with these tests; so their possible influence should be specifically excluded. Whenever possible the omission of all but life-essential medications such as insulin and digitalis for at least several days and preferably a week is strongly recommended, for many patients do not know the name or nature of their numerous medications.

The tests should be performed in a quiet, darkened room with the patient supine on a comfortable bed. After an initial resting period of 20 minutes, blood pressure readings are taken at five minute intervals until stable readings are obtained. During this initial period efforts should be made to gain the patient's confidence and allay all his fears. Just prior to the performance of any test, the technic of the test and the sequence of the side effects, if any, should be explained to the patient. When a drug is to be administered intravenously, the needle should be inserted into the vein, but the injection of the drug should be delayed until repeated determinations of the blood pressure show that the nearly inevitable

pressor effect of the needle puncture has subsided.

The provocative or pressor tests depend upon the sudden release of pressor substances with resulting elevation in blood pressure and precipitation of an attack by stimulation of the tumor with histamine, tetraethylammonium chloride or bromide (TEAC, TEAB or etamon®) or methacholine (mecholyl®, acetyl-B-methyl choline).

The provocative tests are indicated in three groups of patients: those with undiagnosed spells or attacks, those with paroxysmal hypertension and those with sustained hypertension but with the basal blood pressure in the lower hypertensive range, arbitrarily set at below 170 mm. of mercury systolic and 110 diastolic by the Mayo Clinic group.[5,6] They are rarely indicated in patients with sustained basal blood pressures above this level, for experience has shown that under these circumstances, false negative results are not uncommon, possibly because of the inability of the tumor to increase further its production or release of pressor substances.[7] The results of provocative tests are usually considered positive if the administration of the drug is followed by a greater increase in blood pressure than was obtained just previously, during the standard cold pressor test. It should be remembered, however, that the cold pressor test is merely an effort to obtain a standard, but not necessarily maximal, stimulus for measuring vasomotor reactions[8] and that psychic or painful stimulation may at times cause a greater rise in blood pressure than the cold stimulus. One should therefore be hesitant in calling the reaction to a provocative test positive when the blood pressure rise only slightly exceeds the cold pressor response, especially if clinical manifestations of hyperepinephrinism are absent, for this type of response has been noted in patients who are neurotic or hypersensitive to pain as a result of the psychic or painful stimuli from the side effects of the pharmacologic agents used.[9]

One no longer need be fearful of the excessive hypertension and severe symptoms sometimes observed with a positive reaction to a provocative test, for the induced as well as the spontaneous attacks can usually be rapidly terminated or at least greatly subdued by the intravenous administration of one of the adrenergic blocking agents, regitine® or piperoxan, which should be kept readily available during the performance of these tests.

The cold pressor-histamine test is the most reliable and most widely used of the provocative tests.[6,10] Although its use is associated with flushing and a sensation of warmth and is frequently followed by headache of varying severity, it is a safe test if an average amount of care is observed in its performance. The technic is as follows:

The patient is put to bed in a supine position in a quiet, darkened room for at least 20 minutes and until blood pressure determinations at five minute intervals show that the blood pressure has stabilized at a basal level. One hand is immersed to a level above the wrist in ice water of 4 to 5 C. for one minute. The blood pressure is determined immediately before the exposure to cold and every 30 seconds for the next several minutes to detect the maximal rise and then at five minute intervals until it has returned to its basal level. From 0.025 to 0.05 mg. of histamine base in 0.25 to 0.50 cu. ml. of solution is injected instantaneously into an anticubital vein from a tuberculin syringe after the pressor effect of the needle puncture has subsided. The blood pressure is followed at 30 second intervals for five minutes and at one minute intervals for another five to 10 minutes.

Great care should be taken in the calculation and measurement of the histamine dose to avoid either massive overdosage or inadequate dosage, for histamine is available in a wide range of concentrations which are frequently expressed in terms of histamine salts rather than histamine base. Roth[3] emphasized that if a definite drop in blood pressure is not observed 30 seconds after the administration of the histamine, the histamine probably was not given intravenously but into the tissues. Such tests should be considered unsatisfactory and should be repeated after the blood pressure has returned to its basal level.

The results of the test are usually considered positive if the rise in blood pressure within the first two minutes after the injection of the histamine is greater than that obtained with the cold pressor test.

False positive reactions can be expected with distressing frequency if sedatives, narcotics or vasodepressor drugs have been given preceding the test, for they may greatly inhibit the pressor response to cold without comparably influencing the blood pressure response to histamine, pain or psychic stimuli. Furthermore, to quote Roth,

Dockerty and Hightower:[4] "In a few patients with labile blood pressure who are so sensitive to histamine that a severe headache immediately follows its administration, the rise in blood pressure two minutes after a dose of histamine may be equal to or slightly greater than the rise during the cold pressor test. Furthermore, in a few other patients when the headache is very severe, the rise in blood pressure may be greater four to six minutes after the administration of histamine than two minutes after it. This late rise does not indicate the presence of a tumor but rather is due to the pain of the headache."

False negative results have been most infrequent, but they have occurred. Consequently, if the results of the test are doubtful or negative when the clinical evidence is strongly suggestive, the test should be repeated with the 0.05 mg. dose, or one or more of the other drugs should be used.

The tetraethylammonium chloride or bromide test is performed by the intravenous administration of 200 to 400 mg. of either of these drugs over a two to four minute period. The same precautions and technics used in the cold pressor-histamine test to insure basal conditions and to eliminate interfering agents should be employed, for this test has the same basis and the same criteria for a positive result although the rise in blood pressure may be somewhat more retarded and prolonged than with the histamine. The chief side effect is postural hypotension, but to this feature is ascribed the one advantage to the test, namely, that the dangerously high levels of blood pressure obtained in a test giving positive results could be controlled by having the patient sit up or stand. With the availability of the adrenergic blocking agents this type of safeguard is no longer necessary. In view of the high percentage of both false positive and false negative results reported in the literature, this test is definitely inferior to the histamine test.

The mecholyl® test is performed by injecting 10 mg. of mecholyl® subcutaneously, not intravenously, and observing the blood pressure every minute for 30 minutes. Again the same precautions and technics used in the cold pressor-histamine-tetraethylammonium chloride tests should be employed. A rise in blood pressure greater than that of the cold pressor test within 30 minutes after the administration of the mecholyl® is considered a positive reaction. This test has never been popular or extensively used except in one medical center[11] because of the associated unpleasant and sometimes alarming reactions resulting from stimulation of the parasympathetic nervous system end organs. The symptoms include dyspnea, wheezing, flushing and the urge to defecate or urinate. The incidence and severity of these side effects have been decreased but not eliminated by decreasing the dose of mecholyl® from the initially recommended dose of 25 mg. to the present dose of 10 mg. One should always be prepared to control the side effects of this test by the intravenous administration of 1 mg. (1/60 grain) of atropine sulfate should their severity make this obligatory. The subcutaneous administration of this amount of atropine sulfate before the administration of the mecholyl® has been suggested as a method of minimizing the parasympathetic side effects, for their blockage apparently does not block the stimulatory effect of the mecholyl® on functional chromaffin tissue. Reported experience with this test is limited, but it is claimed that false positive results are nonexistent, although there have been several false negative results in patients proved to have pheochromocytoma.

The blocking or depressor tests depend upon the more or less specific adrenergic blocking action that drugs such as piperoxan (2-(1-piperidylmethyl)-1, 4-benzodioxan, 933F or benodaine®), regitine® (2-(N-p-tolyl-N- [m- hydroxyphenyl]-aminomethyl)- imidazoline hydrochloride or C-7337) and dibenamine® (N, N-dibenzyl-B-chloroethylamine) have on circulating epinephrine, norepinephrine and related substances as manifest by a prompt and significant fall in blood pressure in patients with sustained hypertension due to these pressor amines. The ideal drug for this type of test would be one which is easy to administer, nontoxic and of absolute specificity, that is, having little or no depressor effect in hypertension of other origins. Unfortunately, to date no such drug is available, and the agents listed here either lack absolute specificity (regitine®) or are potentially toxic (piperoxan) or both (dibenamine®).

Blocking tests are only indicated in patients with sustained hypertension with higher basal blood pressure levels, that is, above 170 systolic and 110 diastolic, and are not helpful if the hypertension is paroxysmal or below this level.

Although regitine® has had a much shorter period of clinical trial and is definitely a less specific adrenergic blocking agent than piperoxan, it

is already considered the best drug to be used in a screening test for pheochromocytoma in patients with significant sustained hypertension for it is both safer and pleasanter for the patient.[5,12,16] It is free of all side effects except a moderate increase in pulse rate and occasionally a mild sensation of warmth with minimal flushing of the skin. It does not produce the sometimes excessive elevation in blood pressure and associated alarming and potentially dangerous sequelae frequently encountered in patients with essential hypertension after the administration of piperoxan. The intravenous rather than the intramuscular regitine® test is strongly recommended for in the critical evaluation of these tests by Gifford, Roth and Kvale.[5] false negative results were observed only with the intramuscular test. The technic of the intravenous test is as follows: After the patient's blood pressure has reached basal levels and the pressor effect of the needle puncture has subsided, 5 mg. of regitine® in 1 cu. ml. of solution is injected instantaneously into an anticubital vein. The blood pressure is recorded every 30 seconds for three minutes and then every minute for seven minutes longer.

The criterion for a positive reaction is a drop in blood pressure within the first two minutes that exceeds 35 mm. of mercury systolic and 25 diastolic, or from hypertensive to normotensive levels, that is, to less than 140 mm. systolic and 90 diastolic. The drop to normotensive levels is only significant if the basal blood pressure is greater than 170 mm. systolic and 110 diastolic, for false positive results are frequent if the basal blood pressures are below this level for a fall in blood pressure of as much as 30 mm. systolic and 20 diastolic is frequently observed in patients with hypertension due to causes other than pheochromocytoma.[5] False positive results are also observed in uremia, after sedation and although not yet reported might be expected from potentiation of the regitine® effect by various hypotensive drugs or diets. If more than 5 mg. of regitine® is used a decided drop in blood pressure may occur in patients with hypertension of various etiologies, for the margin between the adrenolytic and the peripheral sympatholytic dose of regitine® is narrow. An overlap of these two actions of regitine® in certain patients may be the basis of the otherwise unexplainable false positive results occasionally observed. Because of the possibility of a false positive result, all positive reactions should be checked with piperoxan, one of the provocative tests, or both.

Piperoxan, for several years the only adrenergic blocking agent of any clinical value, has a high specificity, and to date only one false positive response not explainable on the basis of uremia or prior sedation has been reported among the thousands of piperoxan tests performed. Unfortunately, in certain patients with hypertension not due to pheochromocytoma, its injection has been followed by an alarming increase in blood pressure sometimes associated with the clinical pictures of hypertensive encephalopathy, pulmonary edema or acute coronary insufficiency. In addition, the more frequent but merely annoying symptoms of tachycardia, nervousness, cold and clammy extremities, hyperpnea, apprehension, dizziness and warmth combine to make this drug less suitable than regitine® for a screening test. It should be emphasized that these undesirable reactions are not observed in patients with hypertension due to pheochromocytoma, and so its use as a verification test is justified. A negative reaction to a piperoxan test, however, does not exclude the presence of a pheochromocytoma for false negative results have been reported with surprising frequency. These false negative results have been explained by two conflicting theories, either that the persistent hypertension may result from the intermittent secretion of pressor amines which were not present in excess at the time the tests were performed or that, because of its toxicity, not sufficient piperoxan can be given to block the excessively large amounts of circulating pressor amines postulated as being present at the time the tests were performed.[9]

The original technic for the piperoxan test is as follows: With the patient supine, a slow intravenous drip of dextrose in water or normal saline is started into an arm vein through a three way stopcock. After the blood pressure has stabilized, the piperoxan in a dose of 0.25 mg. per kilo of body weight or 10 mg. per square meter of body surface is injected into the vein through the three way stopcock in a two minute period. During this period and for the next three minutes, the blood pressure is determined every 30 seconds and then every minute for 10 minutes longer. The pressure readings are plotted against time in minutes on graph paper. A test giving positive results is indicated by the finding of greater areas below the preinjection base line than above it. The technic has been modified

by use of the direct intravenous injection from a syringe to eliminate the intravenous drip and by the stopping of the injection at once even before the calculated dose has been given should the blood pressure start either to rise or fall precipitously. A significant drop in blood pressure, of the same order of magnitude as for a regitine® test giving positive results, within four minutes after the completion of the injection is considered a positive result.

Dibenamine® no longer has any place in the diagnosis or management of pheochromocytoma now that regitine® and piperoxan are available, for it is less specific, longer acting and has serious local and systemic toxicity.

Space does not permit a discussion of the problems of localization of the site or sites of the widely distributed and sometimes multiple tumors, of their surgical management or of the vital role that drugs have in the control of hypertensive crisis during surgery and of postoperative collapse. Many of these aspects, however, will be covered in the discussion that follows or in certain of the references,[10,13-15] particularly the monograph by Aranow.[1]

Conclusion

An effort is made to show when pharmacologic tests for pheochromocytoma should be performed, what tests should be used, and the pitfalls and limitations of the various tests. Although the results of these tests are not always easy to interpret and although no one single test is always completely reliable, their over-all accuracy is such that surgical exploration is rarely indicated on the basis of the clinical picture alone and in the face of negative results of a battery of properly performed tests.

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550 Brickell Avenue.

Discussion

DR. WALTER C. JONES, Miami: I think Dr. Flipse has made an excellent presentation of this subject from a diagnostic standpoint. I will not attempt to go into it from that phase, but will take it up more from the surgical aspect. I want to emphasize first that this is one of the most dramatic conditions with which a surgeon is faced and necessitates complete cooperation between the clinician, the surgeon and the anesthetist.

In our first case, which occurred about four years ago, we were quite at a loss. At that time there had been little written as to the type of incision. We studied all the material that was available and finally arrived at the conclusion that the best approach was through the anterior transverse incision. I think that has been pretty well recognized now as the type that is most often used. One can cut one or both recti muscles without any hesitancy. This incision gives ample exposure to both suprarenal glands and to the nodes along the aorta. Its value is that one is able to explore other sources of this chromaffin type of material through this incision whereas a posterior approach would limit one to the suprarenal gland on either side, necessitating a double incision rather than one incision. In the exploration I think it is important. I have found it so. It is difficult for me by superficial palpation alone to determine whether or not a small nodule is present in a suprarenal gland. A pheochromocytoma is rather soft and of such consistency that by palpation over the pole of the kidney it is most difficult for me to determine whether or not a tumor is present. I have found it helpful to make a little incision along the lateral border of the kidney and place my finger behind the kidney. In that way obtaining the gland in between two fingers, I can easily determine whether or not the suspected material has a tumor in it.

In the first case of our 2 cases, the patient was a white female aged 47. She was the hypertensive type, maintaining a pressure of around 200 to 220 mm. of mercury with acute exacerbations. As Dr. Flipse has brought out, at that time we did not have piperoxan hydrochloride or regitine®, as this case occurred approximately four years ago, but benzodioxane was used, and the tests with this drug gave positive results. This is a beautiful example of what I like to think of as the chronic type of case, or the hypertensive case in which the operative course was even more dramatic than in our other case. As the slide shows, the patient went on the table with a blood pressure of 200 mm. systolic and 120 diastolic. Induction of anesthesia was begun with a pressure of between 135 and 190 mm. The intratracheal tube caused little disturbance. The operative procedure was begun with the blood pressure between 160 and 128 mm. During the exploration, manipulation of the gland resulted in the blood pressure rising to 280 mm. over 180. There it was maintained fairly well until with dissection it began to show a little drop, and immediately upon excision and removal of the gland, it dropped to nothing. For about two or three minutes the medical men and the anesthetist

fought valiantly to restore it. Eventually it came back to around 130 mm., but the blood pressure had to be watched closely for the subsequent 48 hour period. We kept a medical resident on this case with observation every two to three minutes for the first 48 hours, and the pressure was maintained with the proper pressor drugs.

That is what I like to think of as the crisis type of case. This slide shows another type. In this hypotensive type, the patient was a young man about 28 to 30 years of age who had been most active up until the last six weeks before his exacerbations came on. Hypotension was maintained to a great extent, although the pressure was slightly elevated — 140 mm. over 80 — but the results of pressor tests and histamine tests were positive. His chief complaint was excessive and unbearable headaches. The exacerbations could not be controlled even by the opiates, and the use of the pressor tests and the histamine tests brought on these exacerbations. He went on the table with a fairly stable blood pressure, and there was nothing unusual about it except during the course of manipulation of the gland. Here is brought out what I said a moment ago. We explored the right gland, and at first on superficial palpation I thought there was a tumor in it, but on opening the capsule and exploring with the gland between the fingers I found that the right gland was not involved. There was no gland along the aorta that I could find. So we opened the capsule on the left gland, and after getting the gland between the fingers there was no difficulty at all in determining the presence of the tumor. During this manipulation the pressure was 250 mm., which represents one of the acute exacerbation stages characterizing such cases. When ligation of the vessels was begun, the pressure began to drop off. With the gland removed, it went down by lysis rather than crisis, in contrast to the other case. I do not know whether that is typical of this particular type of case or whether it was because we had the pressor drugs a little more perfected at this time and were able to reduce the pressure more gradually than we were with the previous case in which the drug was not quite so well perfected. The blood pressure was easily stabilized and maintained with much less difficulty than in the previous case. In both of these cases, one occurring four years ago and one approximately two years ago, the patients returned to normal life and have had an uneventful course up to this time. Incidently, they are the most grateful type of patients that we have.

This slide shows the gland uncut in the first case, the chronic hypertensive case. This is the tumor with some normal gland tissue lying in here. We do not hesitate to remove the suprarenal — in fact, it is almost necessary to do so. I do not think we could dissect the tumor out without taking the gland. I cannot. Maybe Dr. Cahill can.

In this slide of the cut section the tumor and the remains of the normal suprarenal gland are shown. The microscopic slides show the excessive amount of chromaffin material throughout these tumors, and even in the second case there were blood vessels in which the chromaffin cells were lying pooled within the vessels. As Dr. Flipse said, it is most difficult histologically to determine whether these lesions are benign or malignant because there are cells circulating in the blood vessels themselves. This first case did not show such cells. This was the chronic type of case, the one with the excessive hypertension, but it illustrates the excessive amount of chromaffin material.

This next slide is similar, again showing the excessive amount of chromaffin material throughout this gland. It shows the norepinephrine secretions.

In this high power view the type of cells may be seen. They are benign, but they certainly worry the pathologists when they first look at them if they have not had some experience with them.

I greatly enjoyed Dr. Flipse's discussion of this subject. The surgeon encounters no more interesting type of case, and again I insist that it demands close cooperation between the clinician, the anesthetist and the surgeon.

Dr. George F. Cahill, New York (by invitation): It is a pleasure to have heard and to be in accord with Dr. Flipse and Dr. Jones. It might be interesting to elaborate upon a few points which they did not have time to emphasize.

The outstanding symptom of pheochromocytoma is hypertension. Of all the patients seen with high blood pressure who might have a pheochromocytoma, the tumor might be in patients who firstly have some sort of paroxysms; secondly, sweating is always associated with the paroxysms; thirdly, there will be hypermetabolism; fourthly, there will occur a high percentage of glycosuria and elevated blood sugar. In a patient with hypertension having these four indications the possibility of pheochromocytoma should be considered.

In such a case how does one prove that a tumor is present? The tumor produces an excess of epinephrine and norepinephrine, both pressor catechols, and they are secreted, either continuously or intermittently. Estimation of the amount of these catechols in the blood is possible, but since they are secreted in the urine at those times, it is possible to identify the catechols and the amounts in the urine. The amounts, normally and in essential hypertension, are known, and in tumor the amount is a great excess over that of either of the former two and at present is the most accurate diagnostic test for tumor.

Once the amount of the catechols in the urine determines the presence of a tumor, it is necessary to locate the site of the tumor. This has been best determined by the use of retroperitoneal gas insufflation. At first we used perirenal injection. At present presacral injection has its wave of enthusiasm. The tumors may be located by angiograms, but personally to date I have not found them as accurate as the retroperitoneal air insufflations. These tumors are of especially low specific density and often they may be overlooked because they outline as cysts and not like the denser cortical adrenal tumors.

Once the tumor is located, it must be realized that in 16 per cent of the cases there may be multiples and about 5 per cent prove to be malignant. It is our custom, because of the possibilities of multiple tumors, to explore by a transverse upper abdominal incision. Through this incision all the possible sites in the abdomen may be explored, and if tumors are present, they may be removed. In the operative procedure two supporting drugs are necessary. At present the best drug to handle the operative paroxysms is regitine,® and secondly, after the tumor is removed, it is necessary to use norepinephrine to sustain the blood pressure. The norepinephrine infusion may be continued for 24 hours to maintain blood pressure stability. We have studied and operated upon 19 of these tumors; 8 in the right adrenal, 3 in the left, 2 in between the vena cava and the aorta, 2 on the right side just above the head of the pancreas, 2 in Zuckerkandl's body, 1 in the lower left splanchic area and 1 in the chest.

MEDICAL DISTRICT MEETINGS

Tallahassee, Oct. 19, 1953 **Tampa, Oct. 21, 1953**

St. Augustine, Oct. 20, 1953 **West Palm Beach, Oct. 22, 1953**

The Use of Insulin in Diabetes

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This has been said to be the medical era of wonder drugs, and the future is bright with promise of more powerful chemical agents to combat infection, destroy malignant disease and influence metabolism. None of the recent discoveries, however, has surpassed insulin in its spectacular effect on the medical world 30 years ago. Insulin immediately saved thousands of lives and permitted those doomed to an early death to live a normal life and a full span of years.

The use of insulin in the treatment of diabetes did not replace the necessity of an intelligent approach to the disease and did not permit neglect of other considerations in the treatment of diabetes; nor did it diminish the importance of accurate diagnosis. Neither should the more recently discovered chemotherapeutic agents; experience will teach physicians to administer them more cautiously and with more specific intention.

Insulin was found to be a two-edged sword capable of doing great harm as well as great good, which is also true of the more recently discovered chemical agents. In order for insulin to be of benefit to the patient, it must be used as a calculated part of an over-all plan of treatment. The diabetic patient must consciously control a vital humoral balance which normally is automatically controlled.

Undoubtedly there is more than one cause for this loss of automatic control and, therefore, more than one kind of diabetes. Each patient with diabetes must be handled as an individual problem, but the basis of medical care for all diabetic patients is education about their disease and its control.

In order to acquaint the diabetic patient with his problem, I frequently compare the normal automatic homeostatic control of the blood sugar level in the body with a thermostatically operated furnace designed to keep a constant temperature in the house.

Sugar derived from the digestion of food is absorbed into the blood stream and, therefore, after a meal, the blood sugar concentration increases. In the normal, this is the automatic signal for secretion of insulin from the pancreas into the blood stream, and the insulin then permits sugar to leave the blood and enter liver and muscle cells where it can be used, thus returning blood sugar concentration to its previous fasting level.

Similarly, as the temperature of a house becomes colder, the thermostat will automatically turn on the furnace, which will return the room temperature to the desired level. The furnace may fail to return the temperature to the proper level either because its fuel supply is exhausted or because of a defect in the thermostat mechanism. The patient may have an abnormally high blood sugar either because the insulin supply becomes exhausted or the control of the insulin supply is defective. In the latter instance there are rapid frequently unaccountable fluctuations of blood sugar, and the diabetic condition is much more difficult to control.

Insulin is required 24 hours a day whether food is ingested or not. Most diabetic patients continue to have some insulin of their own available and require only to have this supply supplemented. In order to provide the release of insulin throughout 24 hours, the regular or crystalline insulins which last only four to eight hours after subcutaneous injection have been combined with various molecules to delay the release of insulin from the site of injection. Effects of a single injection of protamine zinc insulin persist for from 24 to 40 hours and are slow in onset. Globin insulin and NPH insulin injections last from 18 to 30 hours and are more rapid in onset but not nearly so rapid as unmodified insulin.

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 28, 1953.

Diabetic Diet Plans

In order to determine the type and amount of insulin the patient will need, it is necessary first to establish the amount of food he will require for health and work, and when it will be eaten. Physical exertion and sickness will also modify the requirement for insulin.

If the patient will not follow a constant daily diet pattern, it is impossible to control carefully his diabetic condition and useless to attempt to regulate carefully the insulin dosage. Then, as a last therapeutic resort, insulin can be administered in an amount sufficient to prevent diabetic coma and permit glycosuria. Complications of diabetes have been observed to be far more common among diabetic patients who follow this regimen.

Probably more patients with diabetes would observe a daily diet plan if more time had been given to determining the patient's dietary needs and idiosyncracies and the diet prescription had not been so rigid. The Exchange Diet booklets prepared by the American Diabetes Association provide a practical means of instruction and observing diabetic diet plans without requiring that food be weighed.

Most elderly patients who have diabetes do not require insulin for its control, and almost all obese patients would be better off without insulin in that they usually have the disease in mild form and administration of insulin tends to perpetuate their obesity.

Those diabetic patients given restricted carbohydrate diets will require insulin if there is not proper control when they adhere to the required diet. In the majority of those requiring insulin, control is maintained with a single injection of NPH or globin insulin one hour before breakfast. With the patient following a constant dietary plan, the amount of insulin can gradually be increased until fasting and midafternoon blood sugars are below 140 mg. per hundred cubic centimeters. If hypoglycemic reactions occur in the midafternoon and the fasting blood sugar remains high, a milk and bread exchange can be taken from the breakfast and eaten in the midafternoon. If nocturnal reactions occur, a similar ration can be taken from lunch and eaten at bedtime.

Some patients require more rapid action in the morning to prevent a late morning hyperglycemia, which may be provided by adding regular insulin to NPH in small amounts or to protamine zinc insulin in ratios of 2:1 or 3:1 administered 15 minutes before breakfast in one injection. If even more rapid effect is required, the regular insulin may be administered by separate injection. Occasionally in addition to the morning injection an additional small dose of regular insulin will be required at supper time. In a few patients the diabetic condition is best controlled by divided doses of NPH or globin insulin before breakfast and supper.

Conclusion

To determine the best insulin dosage for the individual diabetic patient requires careful observation on a controlled daily diet with frequent tests of the urine for sugar by the patient and occasional blood sugar concentration examinations by the doctor. Subsequently the daily insulin dosage will require variation.

In order to encourage more diabetic patients to follow principles which will control their abnormal carbohydrate metabolism, it is important not to overcomplicate the methods of control. Contrarily, oversimplification will lead to laxity of control and increased complications. The use of insulin provides a means by which diabetic patients may be guided to a healthy, full life by intelligent medical management.

706 Franklin Street.

Discussion

Dr. Richard H. Sinden, St. Petersburg: I want to thank Dr. Hampton for his excellent coverage of a difficult subject and one that he covered extremely well in the short time allotted him. There are two points I should like to say a little more about.

One is with regard to the obese young diabetic patient. I am not sure there is any such person as a "mild diabetic" for in all diabetic patients there may develop the complications which are prone to develop in the so-called "severe diabetic." One must watch therefore the obese patient with mild diabetes carefully. In Dr. Hampton's hands I know the management works well. Others may not be quite as fortunate as Dr. Hampton. If the patient loses too much weight and there develops excessive polyuria, which is one of the ways of flushing out the sugar and reducing weight, there is an excellent chance for neuritis to develop. In many of the patients the neuritis, whichever form it takes, may be quite refractory to treatment.

I like to think of the pancreas as making insulin to reduce the blood sugar to normal when needed, as Dr. Hampton mentioned. If, however, a patient is losing weight and having glycosuria and hyperglycemia, the pancreas is working overtime and will gradually exhaust more and more cells. Then one is liable to find that instead of a patient who requires only a small amount of insulin, one has a diabetic patient requiring many many more units to produce adequate control.

As for the elderly patients with diabetes who are not receiving insulin therapy, many of them now are living longer and longer. I do not know actually what the life expectancy is of persons with diabetes who are aged 70, but probably it is around 10 to 12 years. They do not die of diabetes anymore. They die of the vascular complications of diabetes. So in treating the elderly diabetic patient with hyperglycemia, which allows vascular de-

generation to progress, if the vascular disease has already begun, I think it is worth while to give 8 or 10 units of protamine zinc insulin each morning and keep the blood sugar in a normal range.

There is another point pertaining to the elderly diabetic patient. Many times we physicians examine their urine for glycosuria and fail to get blood sugar determinations. We do not know exactly what produces the premature vascular change in young people and lets it progress more rapidly in the old, but the one thing we do know is that practically everybody so affected has hyperglycemia. I think, therefore, that we should make more blood sugar determinations rather than require more urinalyses in the older patients because in them a high renal threshold frequently develops.

Once again I should like to thank Dr. Hampton for his excellent paper.

DR. MADISON R. POPE, Plant City: I want to thank Dr. Hampton for some excellent thinking on the subject of diabetes. This disease is a problem in my community because there are a good many patients who do not have an intelligent grasp of their condition and who think that it comes like a common cold and disappears just as rapidly. I hope that someday there will be developed an oral preparation of insulin, which I think now is probably considered impossible, but with modern research technics I do not see why it should be. The reason for this hope is that I could name a good many people who will not go to the doctor because they fear they will have to take "shots" of insulin. There are people in my community who, I am sure, have died of untreated diabetes just from that one simple fact, although anyone can be taught to give himself a hypodermic injection or to have some friend do it for him.

Also, I should like to plead for the better control or for some sort of control of the sale of insulin, because I have just learned that insulin is sold across the counter. If a druggist wanted to, he could sell it to anybody who came in his store without violating any law. I got some packages of insulin out and found that the label does not even bear the legend "for prescription use only."

The other day a diabetic patient who was taking NPH insulin called me to ask if she was to continue taking the same kind of insulin, as her supply was out. I replied, "Yes, get your prescription refilled." She went to the drugstore and unfortunately was not waited on by a pharmacist but by a clerk. Instead of requesting that her prescription of a certain number and certain date be refilled, she said, "I want some insulin."

The clerk replied, "Well, Madam, we have several kinds of insulin. What kind would you like?"

"So long as it is a good brand," she said, "I suppose any of them will be all right."

She is now taking 40 units of NPH daily, but he sold her a bottle of regular insulin and on top of that sold her the U 80 variety which she had not been taking. The next morning when she was preparing her hypodermic, she noticed the insulin did not look like that she had had before, but she knew there could not be anything wrong with it because she had bought it at a reputable drug store. So she took what she thought was 40 units, but it was 80 units of regular insulin. Two hours later she went into profound insulin shock, and I thought she was going to die. Fortunately she did not. But up until that time I did not know that insulin was dispensed in that manner. I think it is a shame that we can control drugs like phenobarbital and some others, yet insulin is out for anybody who wants to buy it. Of course, I do not suppose many people want to shop around for it, but this instance illustrates that the diabetic patient who does not understand his condition is in a bad fix.

DR. SIDNEY DAVIDSON, Lake Worth: I enjoyed Dr. Hampton's paper and the remarks of the discussants and was much interested in their plea for good diabetic control. I should like, however, to make a plea for diabetic control which is not too rigid in the older diabetic patient. The elderly person with diabetes, who usually has vascular disease which may have existed prior to the development of the diabetes, is susceptible to hypoglycemia, and the diabetic patient with coronary artery disease may get rather severe repercussions from blood sugars that may be within normal limits. If in an elderly diabetic patient, whose fasting blood sugar has been in the region of 160 to 200 for some days, the blood sugar drops to 110 perhaps, severe angina or a myocardial infarction may develop. I am a firm believer in good diabetic control and follow the Joslin school, but it can be overdone. In the aged diabetic patient with vascular disease I think it is better to err on the high side rather than the low. The elderly patient with diabetes does not get into difficulty when one keeps his fasting blood sugars ranging between 140 and 180. Again I say, let us not have too rigid control of that small group.

DR. HAMPTON, concluding: We have had insulin now for 30 years and it still is not entirely settled how it should be used. It remains a difficult problem. I should like to re-emphasize Dr. Sinden's point about the incidence of complications in diabetic patients. There is no obligate connection between the severity of the diabetes and the severity of the complications. The mild diabetic patients may have various atherosclerotic complications, difficulty with vision, and thrombosis. These complications lead into the field of lipid metabolism, a subject well discussed previously and a most important research problem at the present time.

MEDICAL DISTRICT MEETINGS

Tallahassee, Oct. 19, 1953

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West Palm Beach, Oct. 22, 1953

Effects of Hyaluronidase, Cortisone, Stress and Bacteria on Protective Urinary Colloids and Their Relationship To Renal Calculous Disease

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The importance of each of the many different factors responsible in kidney stone formation continues to evoke interesting controversy. Lithiasis is not a disease entity, per se, but represents a variable physical form of concrement building which may result from an equally variable type of pathology, regardless of its location in the body. Possibly too great emphasis has been placed on the pleomorphism of stone and there has been a reluctance to recognize a more basic biopathologic mechanism.

It is generally accepted, although not conclusively proved, that the formation of renal calculi is a result of an unbalance of the colloidal and crystalloidal matter present in the urine, a highly saturated solution of extremely complex composition. The unusual solubility of stone-forming salts in urine depends upon the presence of certain colloids, which prevent precipitation of salts and other colloids. This protective action of urinary colloids is of major importance in preventing precipitation and conglomeration of crystalloids. If the concentration of such protective colloids is insufficient or not of proper molecular weight, the crystal nuclei are "sensitized" and stone formation begins or is accelerated.

While seeking some agent which may increase the protective urinary colloids, and thereby aid in prevention of stone, we found that subcutaneous injection of hyaluronidase, mixed with physiologic salt solution, resulted in clearing of urine in patients who previously had turbid urine with much sedimentation.[1,2]

From the Butt Medical Foundation, Pensacola; Wyeth Institute of Applied Biochemistry, Philadelphia; Massachusetts Institute of Technology, Cambridge, and Worcester Polytechnic Institute, Worcester, Mass.
Address presented to the Faculty & Fellows of the Mayo Foundation for Medical Education and Research, Rochester, Minn., Nov. 28, 1952.

Testicular hyaluronidase is an enzyme having the property of depolymerizing hyaluronic acid and chondroitin sulfate, the mucopolysaccharides, which are essential components of the intercellular ground substance. Since the addition of hyaluronidase directly to urine does not produce the clearing effect, we proposed that hyaluronidase acted indirectly by the release of hyaluronic acid at the site of injection with subsequent excretion in the urine.[3] Physical chemical studies demonstrated that potassium hyaluronate added to voided urine acted as a powerful dispersing or peptizing agent and that the injection of hyaluronidase resulted in the release of a protective colloid into the urine which dispersed crystalline matter of all types by increasing their solubility.[3]

Urinary sediment of persons not susceptible to kidney stones, when examined ultramicroscopically, is free from "unprotected" crystalline material, but contains the crystalline substance covered with a jelly-like protective colloid. Sediment of the urine from patients with kidney stones shows an abundance of crystalline material and a relative absence of protective colloid. Injection of hyaluronidase promptly alters a pathologic urine so that it appears normal.[4] Under normal conditions, the formation of hyaluronic acid and chondroitin sulfate is a continuous process in many parts of the body. This supplies a hyaluronidase substrate in the urine which maintains the proper colloid-crystalloid balance.

Hyaluronidase Therapy

As a result of determining that injection of hyaluronidase favorably alters the colloidal state of the urine, hyaluronidase therapy was instituted for the treatment of patients with renal calculi.

Observations to date indicate that subjects vary widely in the quantity of hyaluronidase required to clarify pathologic urine and the dosage must therefore be determined individually. Clarification of the urine is the most convenient clinical method so far available for determining response to this treatment.[5] As a supplement to this testing procedure, the response may also be studied by comparing the rate of formation of deposit on indwelling catheters during alternate periods with and without hyaluronidase.

Twenty-nine patients who had been rapid stone formers have been treated with hyaluronidase for periods of 17 to 27 months. Table 1 illustrates the results obtained in these patients. Group A constitutes patients with so-called primary stones and Group B, secondary stones. Figures 1, 2 and 3 illustrate diminution in size and number of calculi following hyaluronidase therapy.

These recent observations may help explain the specificity of certain bacteria in the production of renal calculi, such as has been shown for streptococci by Rosenow[7] and for staphylococci by Hellstrom[8] and Joly.[9]

Surface tension studies on the urine after it has been subjected to ultracentrifuging, by which all matter visible in the ultramicroscope had been removed, have shown conclusively that increased protection due to urinary colloids results in a decrease of the surface tension of the urine.[4] Reduction in surface tension following injection of hyaluronidase closely correlates the clearing of turbidity and sediment if these are present initially. Table 2 shows qualitative determinations of surface tension which were carried out on urine samples from white and Negro males and nonpregnant and pregnant females of the white and Negro races. These findings caused us to consider the possibility of a close correlation between

Table 1. — Summary of Results Following Administration Of Hyaluronidase for Renal Lithiasis

GROUP	Stone Formation Controlled	Stone Formation Slowed	Stones Smaller and Less Dense	Stone Formation Not Controlled
A — 13 cases	8 (61.54%)	2 (15.38%)	1 (7.70%)	2 (15.38%)
B — 16 cases	5 (31.25%)	5 (31.25%)	1 (6.25%)	5 (31.25%)

It was found that hyaluronidase was much more effective in controlling the formation and growth of primary stones, previously considered as idiopathic, than secondary stones, those developing as a result of stasis and infection, hyperexcretion of crystalloids, or other known factors. We propose an hypothesis that the former type of stone is due to a deficiency of protective urinary colloids. It has been determined that dosage requirements of hyaluronidase are much greater in patients harboring urinary infections, especially those due to Pseudomonas aeruginosa, streptococci or urea-splitting organisms, particularly staphylococci or Bacillus proteus.

It has been shown that some of these bacteria produce hyaluronidase and others high molecular weight hyaluronate.[6] Bacterial hyaluronidase differs from testicular hyaluronidase in that the former does not merely depolymerize hyaluronic acid, but carries the process down to end products of low molecular weight which have no effect as protective colloids.[6] High molecular weight hyaluronate has no effect as a protective colloid. Conversely, it acts as a powerful precipitant, the precipitate being a viscous, gluelike substance.[6] the cause for differences in the white and Negro races, differences in the sexes, regardless of race, and pronounced changes during pregnancy.

Table 2. — Comparison of Surface Tension Determinations on Urine From Various Subjects

Type Subject	Surface Tension in Dynes /cm.
White male	65
White female	60
Negro male	55
Negro female	52
Pregnant white female	47
Pregnant Negro female	42

Incidence of Primary Renal Calculi

The incidence of primary renal calculi is more common in men than in women. Secondary stones occur with more nearly equal distribution in the two sexes. The pure bred South African Negro rarely experiences the formation of primary renal stones. In the United States, urinary calculi in the Negro do occur, although with definitely lower incidence than in the Caucasian. This finding is consistent with the fact that a large percentage of the Negro population in the United States is mulatto or has some admixture of white blood. In the mixed races of South Africa, the incidence of

renal calculi approaches that found in the white race.[10]



Fig. 1.—July 28, 1952, roentgenogram showing multiple small calculi, lower calyceal system, right kidney. Left kidney previously removed because of stones. Urine culture B. proteus.



Fig. 2.—August 19, 1952, same patient as in figure 1 following administration of 600 T. R. U. hyaluronidase daily. Roentgenogram shows diminution in size and number of stones.

According to previous concepts, in the pregnant woman, with dilatation and stasis of the urinary tract, often complicated by infection, renal calculi should be especially prone to develop. This concept, however, is not true. Analysis of collected series of 49,000 obstetric cases revealed only 15, or 0.03 per cent, complicated by stone. This percentage would indicate that pregnancy does not predispose to calculous formation, but actually aids materially in preventing the formation of stone. Ultramicroscopic studies of urine of pregnant women revealed pronounced increase in the protective urinary colloids during the latter six months of pregnancy. This effect disappears about six weeks postpartum.

Some collagen diseases undergo remission during pregnancy, and it has been assumed that this benefit is brought about by the increased production of steroids. Seifter[11] stated that the remission may be brought about by the great increase in production and metabolism of hyaluronate occurring as a result of umbilical cord formation and the laying down of ground substance in the fetal



Fig. 3.—October 21, 1952, same patient as in figures 1 and 2. Roentgenogram showing decided diminution in size and number of stones after administration of 600 T. R. U. hyaluronidase daily for three months.

tissues. He also believes that this increase reflects itself in the collagen system of the mother. The well known "bloom of pregnancy" appears in eight to 12 weeks. The infant's skin soon after delivery is soft, smooth and firm. It is probably at these stages that the tissues contain their highest content of hyaluronate. We have observed that in 13 of 26 patients who received large doses of hyaluronidase (300 to 900 T. R. units daily) for a period of several months, their skin became softer and smoother and the subcutaneous tissue more pliable.

Hyaluronidase releases hyaluronic acid at the site of injection, in this case the skin and subcutaneous tissue. The hyaluronic acid begins to reconstitute itself shortly after the hyaluronidase action has been dissipated. During the period of repair, excess hyaluronic acid or hyaluronidase substrate is formed, part of which is deposited in the tissue, the remainder being present in the

blood and then excreted in the urine. Prolonged administration of hyaluronidase does not alter the total urinary volume, and there is no change in the sodium, chloride, potassium, calcium or phosphorus excretion.

Stress Studies

Seifter, Baeder[11,12] and others have shown that hyaluronidase is an excellent tool for attacking the ground substance and that its action is opposed by stress, ACTH and cortisone. It was of interest, therefore, to ascertain whether adrenal steroids administered directly to the patient or released endogenously by stress would affect the urine and antagonize beneficial effects of hyaluronidase. If this were so, it would raise the interesting possibility that urolithiasis is another manifestation of dysfunction of the collagen system.

Aviators were subjected to stress by simulated high altitudes in a compression chamber and centrifuged under accelerations of 3½ to 5 G. In three of the six persons thus subjected to stress there occurred increased cloudiness and sedimentation of urine during the experimental period. Chemical analyses of blood and urine revealed that there was no appreciable shift of the hydrogen ion concentration to account for the increased turbidity and sediment.* Ultramicroscopic studies demonstrated that this was due to decrease or abolition of protective colloids during and immediately following the periods of stress.

Cortisone Therapy

We have observed in 5 of 7 patients receiving cortisone** that the urine became more cloudy with increased sedimentation which could not be completely accounted for by alteration of the hydrogen ion concentration. Ultramiscroscopic studies of urine from these patients revealed a great increase in number of penniform crystals and beginning crystallization (figures 4, 5 and 6). This increase may be noted after administration of relatively small doses, 25 mg. every six hours, and the effects are manifest within six to 12 hours.

Rabbits normally excrete a large amount of sediment in the urine. Seifter and Baeder[12] have shown that adrenalectomy decreases the amount of sediment as does hyaluronidase. The effects of adrenalectomy and hyaluronidase are additive. Poutasse and McCullagh[13] found that renal calculi are a frequent complication of Cushing's syndrome. Greenblatt[14] in a personal communication confirmed this finding and further added that urinary calculi rarely develop in persons with Addison's disease.

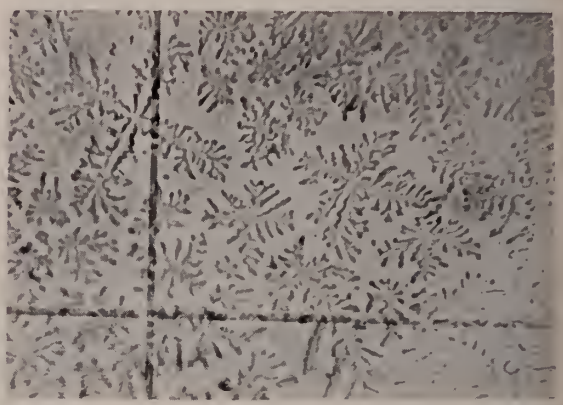


Fig. 4.—Photoultramicrograph of urine before cortisone therapy.

We have also observed clinically that in patients receiving inadequate doses of hyaluronidase calculi develop faster than previously. This same phenomenon occurred when hyaluronidase was administered to patients with poor renal function in which only small amounts of protective colloids were passing through the kidneys. These observations caused us to consider the possibility that cortisone or stress decreased the amount of protective colloids or altered the degree of polymerization of the hyaluronic acid. In either case, the amount of protective colloid is decreased.

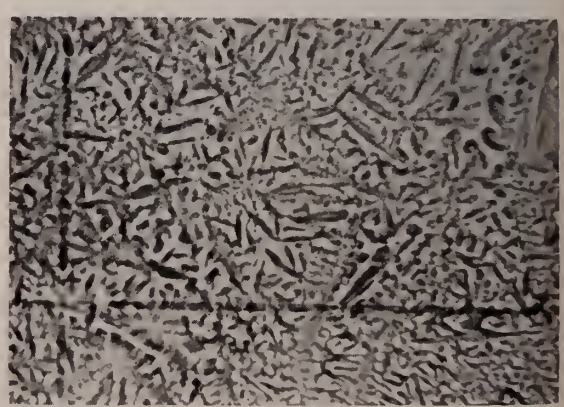


Fig. 5.—Photoultramicrograph of urine of same patient as in figure 4 six hours after administration of 100 mg. of cortisone. Note increase in crystalluria.

From experimental studies, Seifter[11] assumed that the hyaluronic acid in the ground substance is regulated by a buffer consisting of adrenal

*This work was done with the cooperation of the U. S. Naval School of Aviation Medicine, Naval Air Station, Pensacola, Capt. Ashton Graybiel, (MC) U.S.N., and Dr. Dietrich Beischer.

**Generously supplied by Merck & Company, Rahway, N. J.

steroids, some of which enhance the action of hyaluronic acid while others inhibit it. Hyaluronidase may also be involved in enhancing activity of hyaluronate.

Summary

It is proposed that injection of hyaluronidase depolymerizes hyaluronic acid, or a hyaluronidase substrate, part of which is excreted in the urine where it is an excellent protective colloid. By this means, it prevents the formation and development of renal stone. The effect of stress or administration of cortisone appears to render the hyaluronic acid less susceptible or incapable of attack by hyaluronidase. Calculous disease may result from an inhibition of mucopolysaccharides of the ground substance and is therefore another manifestation of dysfunction of the collagen system.

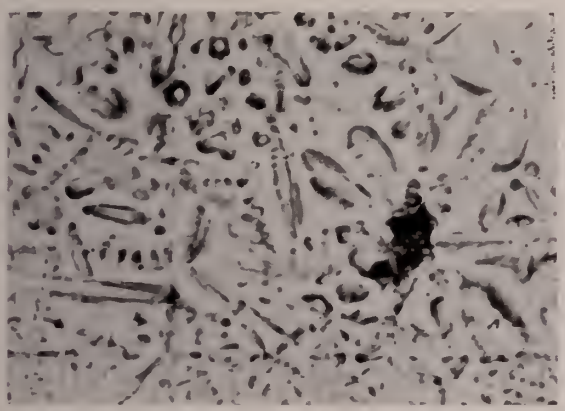


Fig. 6.—Photoultramicrograph of urine of same patient as in figures 4 and 5, 12 hours after 200 mg. of cortisone had been given; 100 mg. at six hour intervals. Note further increase in crystalluria.

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Carcinoid Tumor of Rectum; Report of Case With Review of Literature

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AND
DONALD M. CHRISTOFFERS, M.D.
JACKSONVILLE

There are excellent reviews of the subject of carcinoid tumors of the gastrointestinal tract in the recent literature[1-4] which tend to show that, regardless of the location, carcinoid tumor is not as benign as originally thought when it was first described by Lubarsch[5] in 1888 and designated "carcinoid" by Oberndorfer[6] in 1907. In the opinion of these authors this type of lesion was benign in character although histologically it resembled carcinoma, hence the term "carcinoid." Cases of carcinoid recently reported, however, and a review of the literature show that this tumor, wherever situated, eventually infiltrates and will metastasize to regional and distal sites.

We present 1 case of carcinoid of the rectum, the eighty-second reported in medical literature. Diagnosis was made by biopsy, and no surgical exploration was carried out at other sites for evidence of metastasis at the time of operation.

Report of Case

J. M. M., a 46 year old white man, consulted us because of recurrent rectal bleeding which had apparently occurred from hemorrhoids. This bleeding had been present for several years, but was more frequent and persistent for a month or two prior to our examination. There had been no associated changes in bowel habits. A sigmoidoscopic examination by the local physician had revealed a "polyp" in the rectum, and the patient was referred to us for evaluation of the lesion. Previous roentgen studies with barium sulfate had revealed no evidence of other lesions in the gastrointestinal tract. There was a history of occasional constipation and some abdominal distress with flatulence following meals, but no definite associated food intolerance, abdominal pain, diarrhea, loss of weight or weakness. The stools had been of normal color and consistency.

On physical examination, the patient was a fairly well developed, thin man, whose significant physical findings were confined to the rectum, where there were several internal and external hemorrhoids with evidence of old blood in the perianal region. A mass was palpable on the anterior wall of the rectum at the tip of the examining finger, approximately 8 cm. from the anal margin. It was firm, nodular, freely movable, nontender, measuring about 2 cm. in diameter and situated above the prostate gland. Sigmoidoscopic examination showed the lesion to be a 2 by 2 cm. raised, firm, nodular mass imbedded to a depth of about ⅛ cm. in the anterior rectal wall with the overlying mucous membrane intact. A specimen was taken for biopsy. From this specimen Drs. L. Y. Dyrenforth and E. L. Bishop made a diagnosis of carcinoid tumor of the rectum. An operation was advised.

At operation on July 16, 1952, a posterior approach was contemplated in the belief that the lesion could be excised without entering the peritoneal cavity. A curved incision was made over the coccyx, the muscles were separated, and coccygectomy was performed to obtain adequate exposure. A nodule was then palpated through the upper portion of the incision. There were no other lesions present, and no involvement of the lymph nodes was noted. A longitudinal incision was made through the posterior rectal wall, and the lesion in the anterior wall was excised with removal of all layers of the rectum. The rectal walls were closed transversely. The layers of the wound were sutured around a small tissue drain.

The operative specimen consisted of a portion of intestinal wall measuring 8 by 3 cm. which surrounded a 1 by 1 cm. firm growth showing evidence of recent excision of material for biopsy. On cut section, this mass was well encapsulated, firm, yellow and nodular, lying beneath the mucosa and apparently confined to the submucosal layer of the rectum.

The postoperative course was uneventful. The drain was removed in two days, and the sutures were removed on the fifth day. The patient was discharged on the sixth day. To this date there is no evidence of recurrence or physical findings suggesting metastasis.

Discussion

The name carcinoid is still generally accepted for tumors of this type despite the efforts of Masson[7] and others to call them "argentaffinomas" in deference to their affinity for the silver stain. It has also been suggested that they be called grade 1 Broder classification carcinomas, particularly when they involve the small intestine. These tumors, as demonstrated by Masson,[7] originate in the chromargentaffin or Kulchitsky cell situated in the crypts of Lieberkühn. Segmentally, these tumors can be found along the gastrointestinal tract in proportion to the number of these cells present in a given area. They occur most frequently in the appendix and then in decreasing frequency in the ileum, jejunum, rectum, colon, cecum, stomach, gallbladder and duodenum (ampulla of Vater). In general, the incidence of carcinoids is low. It is recorded that in the commonest site, the appendix, the incidence is .2 to .5 per cent of removed ap-

Read before the staff of Riverside Hospital, Jacksonville, Nov. 25, 1952.

pendixes.[8] An idea of the rarity of rectal carcinoids can be gained from Stout's report of 2 cases in 13,809 routine autopsies; other authors reported 3 cases in 30,000 proctologic examinations.[9] These tumors, however, constitute 20 per cent of all malignant tumors arising in the small intestine.[10]

Characteristically, the tumor consists of a yellow nodule of varying size which occupies the submucosa. The overlying mucosa is usually intact although occasional superficial ulceration occurs. The nodule has a firm, rubbery consistency and may extend through the muscularis to involve the serosa. The cut surface often exhibits fibrous bands dividing it into more or less separate yellow nodules.[11] The tumor may appear at any point on the circumference of the bowel, but it has been noted that it usually does not occur in the area of the mesenteric attachment. In regard to the location of the rectal carcinoid, the incidence is greater on the anterior wall than the posterior wall, being 5 to 10 cm. from the anal margin.[1,2] In our case the lesion was on the anterior wall 8 cm. from the anal margin. Of the 26 cases reported in the literature in which the location of the tumor is given, in 18 it was on the anterior wall.

Carcinoids spread locally by centrifugal expansion. They invade the muscularis and mucosa and ultimately break through the serosa. They ulcerate more slowly than other varieties of gastrointestinal neoplasms and encroach on the lumen of the bowel secondarily.[12] This characteristic accounts for the infrequency of hemorrhage and the insidiousness of obstructive manifestations. Most authors now consider rectal carcinoid as well as carcinoids occurring in other parts of the bowel as definitely malignant but slow-growing and slow to metastasize. Carcinoid tumors spread generally by direct extension and by way of lymphatic channels and also in the perineural spaces to regional lymph nodes. It has also been shown that metastasis takes place through the blood stream.[13]

It is believed by some that the infrequency of metastasis in carcinoids of the appendix and rectum is based on the fact that they give rise to symptoms early. This observation may well hold true for the appendix since symptoms of obstruction occur with the growth of the tumor. In the rectal carcinoids, however, out of 27 cases reported with clinical data, in only 9 were there symptoms referable or probably referable to carcinoid tumor.[1-3] In only 9 out of 82 cases reported was metastasis known to have taken place, and out of 17 in which the carcinoid was locally asymptomatic, in only 1 was there metastasis. We do not believe that early symptoms such as tenesmus, bleeding, rectal pain, or diarrhea, as described by some authors, are the reason carcinoid tumors of the rectum are diagnosed early and so do not have a high incidence of metastasis.

Carcinoid tumors occur in persons of all ages, the earliest age reported being 10 days.[14] Appendical carcinoid tumors are diagnosed with the highest frequency in the third decade and those of the small intestine in the fifth and sixth decades.[15] It is difficult to determine the period of greatest frequency for rectal carcinoids because of the lack of clinical data in most of the cases. From what is reported, there is not much difference in the total number from the second to the sixth decade with the fifth decade ranking first in number of cases.

It is generally agreed from both clinical experience and histologic observation that these tumors both at primary and metastatic sites are slow-growing. Until a larger number of cases have been reported, it is believed that no definite line of treatment can be drawn. At the present time the consensus is that any solitary, freely movable lesions ought to be excised locally and the patient carefully followed with periodic check-ups for recurrence or metastasis. Anal constricting or diffusely infiltrating lesions would appear to call for extensive surgery such as is used in adenocarcinoma of the rectum, with excision of as much of the metastasized lesions as possible.[3]

Ariel[16] and others[17,18] have shown that carcinoid tumors and their metastasized lesions tend to be radiosensitive. Still other writers, however, report conflicting evidence with no changes in the tumor noted following adequate radiation. This form of treatment has still to be studied further.

Summary

A case of carcinoid of the rectum, the eighty-second reported in the literature, is described.

The characteristics of carcinoid tumors, now generally regarded as malignant but slow-growing and slow to metastasize, their incidence with regard to age and site, and their treatment are discussed.

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Riverside Hospital.

ABSTRACTS OF MEDICAL ARTICLES

Intrastate Evaluations of Syphilis Serology. By Albert V. Hardy, M.D. Pub. Health Rep. 67:1036-1038 (Oct.) 1952.

The purpose of this report is to direct attention to the activities of state laboratories in improving the quality of serology in their respective areas. Information was collected by questionnaires addressed to directors of state and territorial public health laboratories. Forty of the 53 laboratories reporting had active intrastate serology evaluation programs involving the intrastate exchange of samples for examination. The extent and duration of these programs in 36 states, two territories and two cities are summarized in a table covering the number and type of laboratories participating, the number of specimens distributed and the number of years the program had been in progress. Of 4,200 laboratories participating, 3,810 were hospital, clinic, or private laboratories, 312 city, county, or regional, and 78 federal.

It is not generally appreciated, Dr. Hardy observes, that the intrastate evaluations are much more extensive than those limited to the central public health laboratory of each state and territory and to author-serologists. Since many laboratories participate in the intrastate studies and few local laboratories have serologists of wide experience on their staffs, the intrastate serology programs have high importance in improving the quality of serology testing available to health officers, physicians and patients.

Results of Three Years Experience with a New Concept of Baby Feeding. By Walter W. Sackett, Jr., M.D. South. M. J. 46:358-363 (April) 1953.

In this article Dr. Sackett relates the story of the origin of the revolutionary schedule of baby feeding he has been employing in his practice for the last three years, together with the reason for its use, its details, advantages and results. It revolves about a six hour feeding interval from birth with the introduction of solid foods as early as the second day of life.

In summary, he states that use of a baby feeding regimen comprising a six hour feeding interval which is rapidly converted to a three-meal-a-day regimen, along with the introduction of food other than milk as early as the second day of life, continues to be a source of gratification to its users. It is also a source of medical interest as these babies continue to follow closely and sometimes even surpass the physical standards set up by babies on more conservative routines. A more detailed survey, now in progress and covering some 300 babies, would seem to emphasize the excellent results a preliminary survey disclosed over a year ago. In addition, these results would seem to be equally satisfactory in babies not under the direct supervision of the author, as the schedule reaches out to friends and relatives of satisfied parents in his own locality, in other states and in foreign countries.

Incidence and Diagnostic Value of the Ocular Fundus Lesions in Hospitalized Medical Patients. By Curtis D. Benton, Jr., M.D. Am. J. M. Sc. 224:554-558 (Nov.) 1952.

This study consisted of careful ophthalmoscopic examination by the author of a series of 500 patients admitted to the medical wards of a general hospital. The purpose of the survey was to determine the incidence of ocular fundus abnormalities in medical patients and to determine how frequently the findings by ophthalmoscopy supplied information of value in the diagnosis of the disease conditions encountered.

Results of the ophthalmoscopic examinations through dilated pupils were: completely normal findings in 222 or 44.4 per cent; intraocular changes relating directly or indirectly to the current medical status of the patient in 203 or 40.6 per cent; various local abnormalities only in the remaining 75 or 15 per cent.

The significant fundal abnormalities associated with anemia, chemical poisoning, diabetes mellitus, gastrointestinal diseases, heart disease, hypertension, acute infectious diseases, kidney diseases, liver diseases, diseases involving lymphatics, diseases involving the central nervous system, phakomatoses, diseases of the lungs, skin diseases and lupus erythematosus are described.

The detection of such physical changes, readily accessible to observation, in so large a percentage of medical patients (40.6 per cent) as this series indicates should be ample reward to the physician who takes time to perform a thorough ophthalmoscopic examination on all of his hospitalized patients.

Double Aortic Arch Associated with Coarctation of the Aorta: Surgically Treated Patient. By Thomas J. Dry, M.B., O. Theron Clagett, M.D., Roy F. Saxon, Jr., M.D., David G. Pugh, M.D., and Jesse E. Edwards, M.D. Dis. of Chest 23:36-42 (Jan.) 1953.

A case is reported in which a 25 year old man had the unusual combination of a vascular ring in the form of a double aortic arch with stenosis of the right (posterior) arch and coarctation of the left (anterior) arch. The usual clinical signs of coarctation of the aorta were exhibited. A vascular malformation in association with the coarctation was suspected from the roentgenoscopic examination, which revealed esophageal compression in the upper part of the thorax. No symptoms of esophageal or tracheal dysfunction were present.

Treatment consisted in resection of the area of coarctation in the left arch with end to end anastomosis of this arch. The continuity of the right arch was interrupted. The postoperative course was uneventful.

Reticulum Cell Sarcoma of the Jejunum. By William J. Clifford, M.D. Am. Surgeon 18: 1164-1167 (Dec.) 1952.

A case of reticulum cell sarcoma of the jejunum is reported, in which perforation first disclosed its presence. The preoperative diagnosis was perforating duodenal ulcer. Extensive resection of the tumor-bearing portion of the bowel and of the mesentery was performed. Although the glands in the resected mesentery showed no evidence of invasion, a superior mediastinal tumor developed four months later. Nevertheless, it is concluded that in cases with a single area of involvement which is accessible, radical surgical removal followed by external irradiation is the treatment of choice.

So far as the author could determine, the case reported is the sixth case of reticulum cell sarcoma of the jejunum recorded in the literature.

Myosarcoma of Trachea Associated with Riedel Struma. By George E. McKenzie, M.D., and Philipp R. Rezek, M.D. A. M. A. Arch. Otolaryng. 57:22-39 (Jan.) 1953.

Since primary tumors of the trachea are extremely rare and sarcomas occur even more infrequently among tracheal neoplasms, the case reported here is of particular interest. In this instance, a primary sarcoma of the anterior wall of the trachea (myosarcoma) was present in association with a Riedel struma. Autopsy findings are related in some detail, and the pathologic diagnosis is substantiated by a review of the literature. The rare occurrence of this type of tumor, its unusual location, and its peculiar combination with a Riedel struma led the authors to report this case.

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From Our President

Free Enterprise System Versus Regimentation

The present status of the practice of medicine rests, as does the status of other professions and businesses, upon the operation of a system of free enterprise. It has been suggested that controls over the systems of medical practice would be advisable, in the interest of providing better and more equitably distributed medical services to the people of these United States.

In our present system of practice, with freedom of choice of physician by patient, and with freedom of practice without regimentation, medical services are available to those persons requiring them and needing them, without regard to their ability to pay for such services. The level of general health in the United States is at the highest level in its history. It is doubtful if there exists now any real shortage of medical personnel.

At the same time, if we are to avoid regimentation and increased controls over our medical practices, either by governmental agencies or by our own medical and surgical societies, and by hospitals in which we practice, we must of our own free wills make adjustments in the methods of medical practice, and meet situations as they arise, in such a way that criticisms will be answered promptly, and differences settled satisfactorily to all concerned.

A just charge for medical service cannot be questioned, for those able to pay for it. Demands for medical services at lower rates, either by group practice on large groups of employees, or by insurers of medical service, cannot be justified and should be resisted by the profession.

Investigation of complaints about exorbitant charges for medical or surgical services, by grievance or mediation committees of our county medical societies, should be made promptly, and responsibility placed where it belongs, whether the physician or patient is at fault. We have it within our own organizations to weed out, or subject to censure, those physicians who are continuing to prejudice our standing, and our relationships, with the persons we serve. Our almost monopoly on medical and surgical practice does not entitle us to act without regard to the effects of such practice on the public, who are necessarily dependent upon us for these services. While many criticisms are unfounded, there must be a grain of truth in some of them. The handling of complaints should be made at the county level, and this is a legitimate and needed function of the county medical society.

Frederick K. Herpel

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The Icon is We

In these days of iconoclastic worship, when ofttimes traditions and beliefs are destroyed merely because they are old, it is amazing that the reverence and awe which the public has for physicians even exists to its present degree. True, the vencration and respect which patients had for their physicians a generation or more ago is diminishing, but still when a physician speaks, his audience usually listens even when the subject is not germane to his profession. Whether esteem for the physician by the laity is desirable to the point where he speaks as an oracle is debatable, but it is most certainly needed for the preservation of that nebulous priesthood of medicine which still cures more ills than antibiotics.

To betray a trust proves one unworthy of keeping it. To use a trust for selfish purposes destroys the meaning of the word. During the past decade when organized American Medicine was about to be smothered by governmental socialistic paternalism, the American physicians united and fought for a freedom they believed rightly theirs and for a type of medicine they thought the American public was entitled to have. Nowhere was this fight better exemplified than in a recent Senatorial election in our own State of Florida. In this the physician resembled America at the outbreak of all of her wars in the past — always unprepared, yet winning by extreme effort, only to return to her previously unprepared state soon after the last cannon blast had stopped reverberating.

Public relations activities have become an integral part of American living and thinking. Whether it be a maudlin soap opera drama which causes housewives to buy a certain brand of deodorant or subtle newspaper fill which causes a ruthless tycoon to appear as a beneficent philanthropist, public relations by advertising or innuendo accomplishes much. The American Medical Association was cognizant of this fact when it hired a public relations firm to aid its fight against government-controlled medicine. But the battle won, even though the war continues, it has dispensed with their services. No one has ever questioned the worth of these paid consultants in time of crisis. Yet, it is hard to understand why their services were dispensed with at a point when for the first time in over 25 years the terms American Medical Association, monopoly, and lobby were not erroneously synonymous in the public mind — almost as difficult as imagining Coca-Cola stopping all advertising because their product became well known.

The Code of Ethics of the American Medical Association, while primarily protecting the patient, definitely gives multiple safeguards to the physician in treating his patient, by preventing the unwanted intrusion of any other physician into the case. Courts of law have upheld time and again that if a physician's treatment was guided by the best of his intentions and knowledge (provided it does not deviate too much from his colleagues' therapy for similar ills), he is blameless for the results of his ministrations should the outcome be unfavorable. It is little wonder, then, that most all physicians are egoists protected as they are by their own ethics and the laws of the land. Added to this is the intangible effect of a physician realizing that every hour of the day he literally has the control of life and death in his hands. Unfortunately, egoists do not tend to form a cohesive or effective group because to do so would be foreign and destructive to their mental makeup. As a result, it is extremely hard for any medical organization to be potent because few if any of its members would be willing to sacrifice any of their rights and privileges for the sake of a group which could in turn control their actions.

Times of crisis create strange bedfellows. Vide the allies of World War II who were previously and are now again de facto belligerents, and former belligerents who are now allies. When American Medicine was threatened with socialization, we sought aid from any one who would succor us. We adopted modern technics for influencing public opinion. A few physicians even gave up some of their valuable time to make public utterances at PTA and other such Main Street meetings on a plane that the average college graduate could vaguely comprehend. Yes, it hurt our pride to have to climb down from our lofty perch and ask patients, who magically became people, for their support. Despite the fact that our antagonists claimed our fight was purely on a selfish basis, and that a breach in the dike of American Democracy would not be accomplished if the government were to enter and reorganize medicine, enough people agreed with us so that we now have a respite from the ever present menace of Socialism. The war was over. We bade farewell to our allies and once again assumed our perch to look patronizingly down upon the people who kept their faith and trust in us.

We constantly read in our newspapers of various laws passed by the state and federal government which pertain to medicine. Most of the time we are not aware of what the law is about and practically all of the time we have no knowledge as to who presented the law or why. In a few cases the law may adversely affect us, for example, the giving of special privileges to cultists, or even nearer to our hearts — the Doctor Draft. We then take off our spectacles, prance up and down hospital corridors, vow to defeat the legislators who voted for the bill and in general let off enough emotional steam to prevent our ulcers from perforating and then promptly forget the whole matter. After all, the law couldn't be too bad! Suppose we do let chiropractors write prescriptions for narcotics? Suppose the physician down the hall was unjustly called back into the armed forces? Yes — egoists we are and egoists we shall remain forever except for the fact that — this is an age of iconoclasm. We as physicians daily question the value of old therapies. Others question social values and relationships. We can no longer hold ourselves aloof from the public and answer in medical mumbo jumbo questions which are their right to know. We can no longer isolate ourselves from the people under the guise of medical ethics or professional dignity. It took two wars and the atom bomb to prove that isolationism is merely a state of mind. Our enlistment of the public in our fight against socialized medicine proves that to resume our isolation from the public is a hypocritical farce, a betrayal of trust in giving the people what is best for them.

Let not the tail wag the dog. We, Hippocratically speaking, are true servants of the people. And our service does not end with the writing of a prescription. Being physicians, we perforce are better educated than the average. Dealing with people, we know human nature better than the average. Prophylactic medicine does not come only in vials and capsules. We, as part of our service, must take a more active interest in public affairs. We must not let politicians prescribe for our patients. If various cults pass legislation with the aid of a well financed lobby not unabashed at handing out presents to legislators, we must combat this action with any means at our disposal. The public must be made aware of it just as they must be forewarned of an impending epidemic. If we believe that certain legislation is necessary for the public weal, we should foster it and see that it passes even though it benefits us none and costs us some.

Once again the American physician is becom-

ing an ogre to the American public. Daily articles appear in newspapers telling of fee splitting, kickbacks, overcharging; magazines feature articles on needless operations, the unavailability of physicians in emergencies. All of this adds up to excellent publicity — but not for American Medicine. We have no adequate means for either defending ourselves or building up our position in the eyes of the people. Our battle ended. We disarmed. We released our public relations firm. We stopped mingling with the masses. After all, the people elect the legislators and if poor sanitary codes or pure food laws are passed, it is their own fault for electing someone who is not too well informed on health measures or perhaps not too honest. We are physicians, too busy to attend to mundane matters of protecting the public from ailments worse than disease. Why should we besmirch our cloak of professional dignity with political matters even though they are of a medical or public health nature? Why should we concern ourselves with everyday problems of nonmedical nature such as honest government? Or are we citizens, too?

No general ever won a battle remaining on the defensive. If the associated medical sciences had progressed only as far as physician-patient relationship, we would still be practicing blood letting and wearing frock coats in operating rooms. It is time, physician, to heal thyself. It is time to keep a trust placed in you by the American public by participating as a true physician in all things pertaining to health whether it be in Washington or city hall. It is time to let the public know what a physician's life really is, what he really does gratis, what gifts he has bestowed on American life, and in no better way can these objectives be accomplished than by adequate expert public relations. It is time to become a real citizen and person.

This is an age of iconoclasm. It is indeed dangerous for an egoist to stand on a pedestal in front of a mirror admiring what he believes he sees. If the practice continues, he may find the pedestal removed, the mirror shattered, and the image he so ardently admired a nothingness which is himself.

1953 Medical District Meetings

"A", Tallahassee	October 19
"B", St. Augustine	October 20
"C", Tampa	October 21
"D", West Palm Beach	October 22

Gastronomy of Yesteryear

In these days of phenomenal advances in the science of nutrition, and incidentally of remarkably increased longevity, there are those who cherish a nostalgic longing to hark back to the good old days. A savory item furnishing food for thought came to light at the recent meeting of the American Medical Association in New York. This meeting was the centennial for one held there 100 years ago. During the 1853 meeting the physicians of New York City entertained the visiting doctors at dinner in Metropolitan Hall, a bit lavishly it would seem, even for physicians in those times.

The bill of fare offered three soups, four fish, six boiled meats, eight roasts, and two cold dishes, including boned turkey and boar's head. There followed 16 entrees from which to choose, and for game the choice of five included grouse, red heads, broad bills, brandt and squabs, not to mention 10 vegetables, pickles and olives. In addition, pastries and confections numbered 11, and there were five ices for good measure. To vanquish remaining pangs of hunger, the visiting physicians and their hosts could turn to seven varieties of fruit as they lingered over their coffee.

The photostatic copy of this menu presented to the editor of the Journal of the American Medical Association is no doubt a prized possession (J. A. M. A. 152:712, June 20, 1953). Certainly it is century-old evidence of the admirable way in which men of medicine across the years have filled the role of gracious host. Mere contemplation of the sumptuous repasts of yesteryear have their gastronomic appeal, and not alone to the epicure, but even Southern hospitality in the best tradition would quail at a return to feasts of the good old days at today's prices.

Does Your Journal Keep You Posted?

Look before you leap is time-honored advice. On occasion, read before you suggest also might be. When an effort was made at the Graduate Short Course last June to obtain suggestions on how to disseminate information more widely in an effort to interest more physicians in the course, two doctors at different times in almost identical words obligingly proposed that The Journal carry this information. Of course, the full page sched-

ule of the annual June Short Course appears in the May issue each year with accompanying mention of the faculty. Also, appropriate notices published for several months before the meeting and a summary of the high lights of the course published afterward provide ample coverage of this important annual event for those who have eyes to read.

Not too long ago, the suggestion was made that The Journal have a table of contents. Naturally, it has always had one, and now carries a full page spread that could hardly be missed. Even he who runs may read, scanning the items without difficulty.

The Editors are nevertheless gratified that those who read carelessly or not at all regard The Journal as a foremost source of information on matters of moment to the members of the Association. Too, they welcome constructive suggestions leading to its greater usefulness to the members. The Journal strives always to serve well those to whom it belongs.

Changes in Disease Incidence

During the first six months of this year there was a sharp increase in infectious hepatitis over the same period in 1952, and a sharp decrease in measles. In the same period, the decrease in malaria among civilians was significant, and the decrease among military personnel was particularly noteworthy, amounting to almost 90 per cent. Acute poliomyelitis cases increased by about 25 per cent. These figures were recently announced by the National Office of Vital Statistics.

Physicians Almost Everywhere

One sixth of the United States, in April 1950, was beyond a radius of 25 miles from a physician in active private practice. These 509,000 square miles, however, had but 237,000 inhabitants, or one fifth of 1 per cent of the entire population of the United States. These wide open spaces, where the nearest neighbor frequently is many miles away, are located mostly in the Rocky Mountain and Great Plains regions. The relatively small number of residents in this territory certainly disproves the numerous claims of recent years about the unavailability of physicians' services in many parts of the United States. Bringing the true situation to light should settle many an argument.

This interesting finding is but one of many facts established by the Bureau of Medical Economics Research of the American Medical Association and the state medical associations in a joint study of medical service areas begun some years ago. The Bureau has recently published a 39 map supplement (Bulletin 94A) to a book (Bulletin 94) to be published soon, and on its 61 pages of maps are 15,192 marks indicating places in which one or more physicians are located. A mere glance at these maps indicates that physicians are located almost everywhere, except in the sparsely settled regions of the West.

Report of Delegates to American Medical Association, 102nd Annual Session June 1-5, 1953, New York City

The House of Delegates of the American Medical Association, in session at the Waldorf-Astoria Hotel during the 102nd Annual Meeting of the A. M. A. in New York City, took important policy actions on veterans' medical care, medical ethics, osteopathy, intern training and a wide variety of subjects ranging from medical education to public relations.

The House also named Dr. Walter B. Martin of Norfolk, Va., as president-elect of the American Medical Association for the coming year. Dr. Martin will become president at the June 1954 meeting in San Francisco, succeeding Dr. Edward J. McCormick of Toledo, Ohio, who took office at a special inaugural session of the House of Delegates in the Hotel Commodore during the New York meeting.

The New York meeting was the largest ever held in the history of the American Medical Association, with the final figures on total attendance expected to reach or surpass 40,000, including nearly 18,000 physicians.

Giving unanimous approval to a recommendation from its Reference Committee on Insurance and Medical Service, submitted as a substitute for eight different resolutions concerning the treatment of non-service-connected disabilities by the Veterans Administration, the House adopted the policy that such treatment should be discontinued except in cases involving tuberculosis or psychiatric or neurological disorders.

In taking this action, the House reaffirmed and adopted the following recommendation originally presented at the Denver meeting last December by the Special Committee on Federal Medical Services:

"Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administra-

tion and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

"(a) Veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and

"(b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

The reference committee report adopted by the House expressed complete accord with the present program of hospital and medical care for veterans with service-connected disabilities, and also included this statement:

"It is the belief of your committee that the medical profession must concern itself, not with the numbers of 'chiselers' in Veterans Administration hospitals nor with the efficacy of the Veterans Administration in the administration of enabling legislation, but rather with the broad question of whether such legislation is sound, whether the federal government should continue to engage in a gigantic medical care program in competition with private medical institutions and whether the ever-increasing cost of such a program is a proper burden to impose on the taxpayers of the country. A consideration of this problem must of course be predicated upon a concern for the health of the entire population and not just a particular segment."

Eleven resolutions dealing with publicity regarding unethical conduct of physicians were brought before the House as a result of recent newspaper and magazine articles reporting statements attributed to an official spokesman of an allied medical organization. The House adopted a committee report which recommended no action on the 11 resolutions but which reaffirmed the supremacy of the A. M. A. code of ethics and urged that the Judicial Council study suggested revisions concerning methods of billing.

"The Principles of Medical Ethics as formulated, interpreted and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession," the reference committee report said. "Any statement relating to ethical matters by other organizations within the general profession of medicine advances views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

Condemning generalized statements regarding the ethics of physicians, the report went on to say:

"Your reference committee believes that the harm done to the public and to the profession by the current articles which lower the confidence patients have in their doctors cannot be objectively evaluated. This highlights the fact that, when individuals or groups without official status in the American Medical Association utter or publish ill-considered statements, the result too often is that the confidence of the public in the medical profession is placed in jeopardy.

"The reference committee believes that the members of the House of Delegates have demonstrated their devotion over the years to the principles of American democracy. This devotion includes the right of free speech. With this, the Committee agrees unqualifiedly.

"Broad generalizations, ill-advised and poorly prepared statements that often fail to convey the intended meaning are most unfortunate and are to be deplored. Destructive critical comments serve no useful purpose. Your committee has the utmost confidence that the great majority of our members are entirely capable of avoiding these pitfalls without additional advice from this committee."

The report also urged that the American Medical Association continue to inform its members and the public of its stand on matters pertaining to abuses and evils in the practice of medicine.

Most controversial issue brought before the House at the New York meeting proved to be the question of immediate or deferred action on the report of the Committee for the Study of Relations Between Osteopathy and Medicine. The House, after two hours of vigorous, spirited debate, adopted the majority report of the Reference Committee on Miscellaneous Business, thereby postponing action until the June, 1954, meeting and allowing further study by the delegates and the state associations.

The recommendations of the Committee for the Study of Relations Between Osteopathy and Medicine were as follows:

"1. That the House of Delegates declare that so little of the original concept of osteopathy remains that it does not classify medicine as currently taught in schools of osteopathy as the teaching of 'cultist' healing.

"2. That the House of Delegates state that pursuant to the objectives and responsibilities of the American Medical Association, which are to improve the health and medical care of the American people, it is the policy of the Association to encourage improvement in the undergraduate and postgraduate education of doctors of osteopathy.

"3. That the House of Delegates declare that the relationship of doctors of medicine to doctors of osteopathy is a matter for determination by the state medical associations of the several states and that the state associations be requested to accept this responsibility.

"4. That the Committee for the Study of Relations Between Osteopathy and Medicine or a similar committee be established as a continuing body."

A minority report of the reference committee urged approval and adoption of those recommendations at the New York meeting. The majority report, which ultimately was adopted, included the following recommendations by the Board of Trustees:

"Because of the length of the report and the controversial nature of the subject, the Board feels that the House should have adequate time for its study and that the state associations should have opportunity to express their opinions.

"Therefore, it is recommended that the Committee be continued but that action on the report be deferred until the June, 1954, session. It is suggested that at that time the House be prepared to answer the following questions:

"1. Should modern osteopathy be classified as 'cultist' healing?

"2. Since the objectives of the American Medical Association include improvement in undergraduate and postgraduate education, should doctors of medicine teach in osteopathic schools?

"3. Should the relationship of doctors of medicine to doctors of osteopathy be a matter for determination by the several state associations?"

Five resolutions came before the House with regard to the Essentials of an Approved Internship, which were adopted at the December, 1952, meeting. The Reference Committee on Medical Education and Hospitals recommended a substitute resolution which was adopted by the House after considerable discussion. The action abolishes the rule whereby approval may be withdrawn from an internship program that for two consecutive years fails to obtain at least two-thirds of its slated complement of interns. The resolution also calls for further study of the essentials by a committee appointed by the Speaker of the House, at least half of whom are physicians in private practice not connected with medical schools or affiliated hospitals.

Among the many other actions taken, the House reaffirmed its endorsement of the principles embodied in Senate Joint Resolution No. 1 concerning international treaties or agreements which interfere with domestic laws or right, and it approved a resolution deploring a derogatory article about the American Medical Association which appeared recently in the Home Life Magazine. The latter resolution was referred to the Board of Trustees for implementation.

Highlights of the opening day session of the House were addresses by Dr. Louis H. Bauer, who delivered his term-end report as retiring president; Dr. Edward J. McCormick, who spoke on that day as president-elect, and Mrs. Oveta Culp Hobby, United States Secretary of Health, Education and Welfare, and selection of the winner of the 1953 Distinguished Service Award.

Dr. Bauer, referring to charges of unethical practices among some doctors, declared that all members of the medical profession "should not be tarred with the same stick."

Dr. McCormick outlined a nine point program for further improvement in the nation's medical care and expressed the hope that "their further development will solve many of medicine's problems and eliminate much of the criticism to which we are subjected."

Mrs. Hobby told the delegates that the present administration in Washington is looking with confidence to the nation's physicians for leadership in meeting the challenge of modern medical care problems.

The 1953 Distinguished Service Award was voted to Dr. Alfred Blalock of Baltimore for his outstanding work in vascular surgery and his part in the development of the so-called "blue baby" operation. Dr. Blalock, chief surgeon at Johns Hopkins Hospital and professor of surgery at Johns Hopkins University School of Medicine,

received the award during ceremonies preceding the presidential inauguration Thursday night, June 2.

In addition to the selection of Dr. Martin as president-elect, the House also elected Dr. Carl H. Gellenthien of Valmora, N. M., to the office of vice president. He succeeds Dr. Leo F. Schiff of Plattsburgh, N. Y.

Re-elected to office were:

Dr. George F. Lull, Chicago, Secretary and General Manager; Dr. J. J. Moore, Chicago, Treasurer; Dr. James R. Reuling, Bayside, N. Y., Speaker of the House of Delegates; Dr. E. Vincent Askey, Los Angeles, Vice Speaker of the House; Dr. Edwin S. Hamilton, Kankakee, Ill., and Dr. Gunnar Gundersen, La Crosse, Wis., as members of the Board of Trustees.

The House elected Dr. Julian P. Price of Florence, S. C., to fill Dr. Martin's unexpired term on the Board of Trustees. The House elected Dr. Louis M. Orr, II, of Orlando as a member of the Council on Medical Service. Dr. Louis M. Orr, II, was re-elected Chairman of the Committee on Federal Medical Services. Dr. Homer L. Pearson, Jr., of Miami is at present serving a five year term as a member of the Judicial Council.

* * * * * *

Resolutions Introduced by the Florida Delegation and Action by the House of Delegates

1) Resolution on Paul R. Hawley, FACS:

WHEREAS, Over the past few years it has been the avowed desire of the American Medical Association and its component societies to promote a policy of improved public relations; and

WHEREAS, This policy has been, through the efforts of specific committees and individual members, attended with a remarkable degree of success; and

WHEREAS, This state of favorable public relations has been alluded to as the greatest bulwark against the advent of socialized medicine; and

WHEREAS, The greatest blow to this policy on public relations and a consummate and open violation of the code of medical ethics has been accomplished through the public utterances of a member of the American Medical Association in regard to splitting of fees, unnecessary surgery, and ghost surgery, namely, Dr. Paul R. Hawley, and this undesirable effect has been fostered by the equally public affirmation of another member of the American Medical Association, namely, Dr. Evarts Graham; and

WHEREAS, This unfortunate publicity has created distrust of and has lowered public confidence in physicians generally; therefore be it

Resolved, By the Florida Medical Association that such methods of attacking the problem of unethical practices are unsound and are opposed to the best interests of the public and the medical profession; and be it further

Resolved, That a copy of this resolution be spread upon the minutes of the Florida Medical Association, and that a copy be sent to the Chairman of the Board of Regents of the American College of Surgeons; and be it further

Resolved, That this resolution be carried to the floor of the House of Delegates of the American Medical Association by the delegates of the Florida Medical Association so that it can be given proper consideration and appropriate action.

Action on this Resolution: Your committee recommends no action on this resolution but instead that the House give careful objective consideration to the ethical problem involved.

This resolution was one of 11 introduced and action on all resolutions may be summarized by the following statement patterned after the resolution introduced by the delegate from Wisconsin:

"The Principles of Medical Ethics as formulated, interpreted, and applied by the American Medical Association must be considered the only fundamental and controlling application of ethics for the entire profession. Any statement relating to ethical matters by other organizations within the general profession of medicine advance views of only a particular group and is without official sanction of the entire profession as represented by the American Medical Association."

2) Resolution on General Practitioner Award: (presented by Dr. Louis M. Orr, II)

WHEREAS, The medical profession and the nation's medical schools are currently making a definite effort to encourage a revived interest in general practice; and

WHEREAS, There is positive evidence that during the past four or five years an increasing percentage of medical students plan to enter general practice; and

WHEREAS, Throughout the nation many young physicians already are making excellent records as general practitioners; therefore be it

Resolved, That the American Medical Association, in its annual selection of the General Practitioner of the Year, make a definite effort to give

consideration to the younger physicians who are doing fine work as family doctors.

This resolution was referred to the Reference Committee on Reports of Board of Trustees and Secretary. Action was as follows:

Resolution on General Practitioner Award: After careful consideration of this resolution, your committee believes that no action on it is needed, because adequate consideration is already being given to its objectives by the Board of Trustees.

3) Resolution on Today's Health:

Dr. Louis M. Orr, II, Florida, introduced the following resolution, which was referred to the Reference Committee on Reports of Board of Trustees and Secretary.

WHEREAS, We are highly conscious of the potency of the physician's office as an integral part of sound medical public relations; and

WHEREAS, We are of the belief that the American Medical Association's publication *Today's Health* is designed to serve the interests of the lay public from the standpoint of good health information; and

WHEREAS, We feel more physicians' offices should have a copy of *Today's Health* available to the physicians' patients; now therefore be it

Resolved, That the Florida Medical Association petition the House of Delegates of the American Medical Association to authorize the setting aside of $1.50 of the annual dues of each of the dues-paying members of the American Medical Association for the purpose of purchasing a subscription to *Today's Health* to be addressed to the office of each of the physicians.

Action by Reference Committee:

Resolution on "Today's Health": The adoption of this resolution would necessarily cause a large increase in the expenditure of funds by the Association. In addition, other plans have been proposed for a wider distribution of Today's Health. Therefore, your committee recommends that this resolution be not adopted.

This report is respectfully submitted,

Louis M. Orr, II
Delegate
Reuben B. Chrisman, Jr.
Delegate

Tri-State Obstetric Seminar September 14-16, 1953

The Tri-State Obstetric Seminar will be held at the Sheraton Beach Hotel in Daytona Beach on September 14, 15 and 16. Sponsors of the meeting are the Committee on Maternal Welfare of the Florida Medical Association and the Bureaus of Maternal and Child Health of South Carolina, Georgia and Florida.

On Monday morning, September 14, the distinguished lecturers and their subjects will be: "Heart Disease in Pregnancy," Dr. Charles A. Poindexter, Professor of Medicine, New York University-Bellevue, New York; "Surgery on the Pregnant Woman and the Newborn Child," Dr. Alton Ochsner, Director, Division of Surgery, Ochsner Clinic, New Orleans; "Operative Obstetrics," Dr. M. Edward Davis, Joseph B. DeLee Professor, Obstetrics and Gynecology, the University of Chicago, Chicago; and "Anesthesia and Analgesia in Normal and Operative Obstetrics," Dr. Perry P. Volpitto, Professor of Anesthesiology, Medical College of Georgia, Augusta.

Two lectures will open the program on Tuesday morning: "Intra and Postpartum Hemorrhage," Dr. Allan C. Barnes, Professor of Obstetrics and Gynecology, Ohio State University, Columbus; and "Abortions," Dr. Carl P. Huber, Professor of Obstetrics and Gynecology, Indiana University, Indianapolis. There will follow a discussion on Maternal and Fetal Mortality Trends in South Carolina, Georgia and Florida by representatives from state health departments and state medical associations with Dr. E. Frank McCall of Jacksonville serving as moderator.

Wednesday is designated Pediatric Day, and on that morning the program will consist of three lectures: "Maternal and Infant Factors Relating to Prematurity," Dr. Edith L. Potter, Associate Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago, Chicago; "Problems of the Premature Infant," Dr. Robert B. Lawson, Professor of Pediatrics, Bowman-Gray School of Medicine, Wake Forest College, Winston-Salem, N. C.; and "Care of the Newborn Infant," Dr. Hugh A. Carithers, Jacksonville, Florida Chairman and member of Committee on Foetus and Newborn, American Academy of Pediatrics.

Round table discussions are scheduled for Monday afternoon, Tuesday night and Wednesday afternoon. Dr. Fred L. Adair, former Professor of Obstetrics and Gynecology, University of Chicago, Chicago, will lead the guest speakers in their participation in these discussions. Tuesday afternoon will be devoted to recreation.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. John H. Tanous of Miami Beach announce the birth of a son, John Harrington, III, on June 2, 1953.

Dr. and Mrs. Hyman Merlin of Miami announce the birth of a son, Ellis Jay, on June 28, 1953.

Dr. and Mrs. Clifford E. Vinson of Williston announce the birth of a son, Joseph Hjalmar, on July 2, 1953.

Dr. and Mrs. Thomas C. Frell of Hialeah announce the birth of a son, Thomas, on July 7, 1953.

Dr. and Mrs. George P. Beach of Daytona Beach announce the birth of a daughter on July 12, 1953.

Dr. and Mrs. Samuel M. Wells of Jacksonville announce the birth of a son, Samuel Mauldin, Jr., on July 26, 1953.

Dr. and Mrs. George I. Raybin of Jacksonville announce the birth of a daughter, Judith Ann, on Aug. 2, 1953.

Marriages

Dr. Cecil M. Hogan and Mrs. Marjorie Pat Ray, both of Jacksonville, were married on Aug. 1, 1953.

Deaths — Members

Palay, Lewis, Miami Beach ..... July 16, 1953

Deaths — Other Doctors

Romano, Joseph J., Coral Gables ..... March 26, 1953
Bull, Homer T. R., Geneseo, N. Y. ..... June 1, 1953

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Beaumont, Godfrey L., Sebring
Habegger, Myron L., Cocoa
Hodges, Leonard I., Coral Gables
Migliore, Anthony D., Arcadia
Parks, Raymond E., Miami
Perdue, Maxine R., Miami
Roy, Robert L., Miami
Schmidt, Ivan C., West Palm Beach
Wilson, Robert D., Tampa

Medical Officers Returned

Dr. Bennett B. Harvey, who entered military service on Oct. 14, 1950, was released from active duty on Feb. 28, 1953 with the rank of major, U.S. Army. His address is Laboratory Service, V. A. Hospital, Lake City.

STATE NEWS ITEMS

Dr. Vernon L. Fromang of Vero Beach spoke on polio at a meeting of the Kiwanis Club of Vero Beach in July.

Dr. Chester H. Murphy of Bartow represented the Bartow Rotary Club at the International Convention held in Paris in May.

Dr. James N. Patterson of Tampa has returned to his practice after attending a two weeks course in hematology at Michael Reese Hospital in Chicago in July.

Dr. Walter T. Hotchkiss of Miami Beach has been elected to a three year term on the Board of Directors of the American Hearing Society.

Dr. Walker Stamps of Jacksonville was reappointed to the Duval County Welfare Board by Governor Dan T. McCarty.

Dr. Aubrey Y. Covington of Starke served two weeks, July 5 to 19, on annual maneuvers with the Medical Corps Florida National Guard at Fort McClellan, Ala.

Dr. Nathaniel M. Levin of Miami has been awarded a citation for his work in rehabilitating the handicapped by the Miami Chamber of Commerce's Employ the Physically Handicapped Committee.

Dr. Hugh West of DeLand has taken a leave of absence from his practice to travel abroad, during which time he will visit hospitals in London and in Heidelburg, Germany.

Dr. Frederick E. Farrer of Miami spoke at a meeting of Gamma group of Delta Zeta in July.

Dr. Edwin P. Preston of Miami received an appreciation plaque for his "outstanding service" as president of the Heart Association of Greater Miami. He was presented the plaque by his successor, Dr. Milton S. Saslaw of Miami.

Dr. Fred H. Albee, Jr., of Orlando has accepted an Annie C. Kane Fellowship in orthopedic surgery at the New York Orthopedic Hospital, to begin September 1, 1953. This Hospital is a component part of the Columbia Presbyterian Medical Center. Dr. Albee will be away from his practice for one year.

Dr. Arthur R. Beyer of Tampa announces the association of Dr. Philip G. Creese with him in the practice of general surgery at 405 Citizens Building.

Dr. Richard F. Stover of Miami has been elected president of the Dade County Health Council.

Dr. James D. Moody of Orlando entered medical service with the U. S. Army on July 3, 1953 with the rank of captain.

Scientific Program for the 80th Annual Convention: Plans are now underway for the preparation of the Scientific Program for the 80th Annual Convention of the Florida Medical Association to be held at Hollywood, beginning April 25, 1954.

It is most desirable that the high quality of the previous programs be continued. In order to do this, your committee must have many papers and a wide range of subjects. It is, therefore, urged that you submit any proposed papers together with a brief resume of the subject to be discussed to the committee at an early date.

Applications must be received by early November, 1953 and should be mailed to Jere W. Annis, M.D., Chairman, Scientific Work Committee, Box 1021, Lakeland, Florida.

Specialty groups desiring their speakers on the state program must advise the Scientific Work Committee by November.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

LOST: One old gold earring with small diamond during Annual Convention Hollywood Beach Hotel. Very valuable to owner. Reward. Write William H. Grace, M.D., 71 First Street, Fort Myers, Fla.

FOR SALE: "Profexray" twenty milleamp stationary x-ray with fluoroscope, wall casette holder, all equipment. Half price. Located Panama City, Florida. Write Donald Anderson, M.D., 1013 Royal St., New Orleans, Louisiana.

LOCATION WANTED: Surgeon, Board Certified, age 36, married, category IV, interested in group or association or location to practice. Will do small amount of general practice in turn with a group. No OB. Write 69-97, P. O. Box 1018, Jacksonville, Fla.

DOCTOR: Wishing affiliation, partnership, or to buy general and obstetrical practice, or will rent space to doctor wishing to locate near new Baptist Hospital. Write C. D. Rollins, M.D., 1402 Miami Rd., Jacksonville, Fla.

FOR SALE: Fully equipped office and large general medical practice on Lincoln Road, Miami Beach, X-Ray, Electrocardiograph, Basal, Microtherm, complete laboratory, colorimeter, Frigidaire, many rooms. Price reasonable. Illness. Write 4000 Collins Ave., Room 105, Miami Beach, Fla.

COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society has paid 100 per cent of its state dues for 1953.

Broward

Members of the Broward County Medical Association are giving a series of free lectures on medicine in Fort Lauderdale. The course is sponsored by the adult and vocational division of the county's public school system, and the classes are being held on Tuesday and Thursday nights.

Dade

The regular monthly meeting of the Dade County Medical Association was held on August 4. No scheduled scientific programs were presented at the summer meetings.

The Dade County Medical Association has ordered 1,000 A.M.A. office plaques, "To All My Patients," to be placed in each doctor's office.

Lake

Dr. Lorenzo L. Parks of Jacksonville spoke to the Lake County Medical Society on August 5 on "Poliomyelitis and the Gamma Globulin Supply."

(Continued on page 196)



The inevitable restrictions of advancing years, the reduced activity and a lowered intake of bulk-producing foods all contribute to the high incidence of constipation in older persons.

CONSTIPATION IN THE AGED

Constipation is almost a universal complaint of geriatric patients

Frequently, too, the protracted use of cathartics has left the colon in an atonic state and it is no longer capable of effecting a normal evacuation.

Metamucil has long been recommended for the treatment of constipation in the elderly. A highly refined vegetable product which is free from irritants, Metamucil effects a natural mechanical stimulus in the colon which helps the dysfunctioning muscles to regain and maintain their normal tone.

Metamucil may be safely prescribed for prolonged use without fear of dependence, intestinal irritations or allergic reactions.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE *Research in the Service of Medicine*

(*Continued from page 194*)

Manatee

The Manatee County Medical Society cooperated with the Bradenton Junior Woman's Club, the Manatee County Health Department and the State Board of Health in sponsoring a diabetes survey in Manatee County in July.

The Manatee County Medical Society has paid 100 per cent of its state dues for 1953.

Palm Beach

The series of free medical forums sponsored by the Palm Beach County Medical Society was discussed at a called meeting on July 28. The first topic discussed on August 4 was "Facing Facts About Cancer."

Sarasota

Dr. Frederick D. Droege, Sarasota, chairman of the Committee on Public Relations, Sarasota County Medical Society, has announced that the Society will sponsor a radio program.

OBITUARIES

Daniel Angus McKinnon

Dr. Daniel Angus McKinnon of Marianna died on March 17, 1953, in Bataan Memorial Hospital, Albuquerque, N. M., after a lingering illness. He was 75 years of age. Interment took place in Albuquerque.

A native Floridian, Dr. McKinnon was born in Marianna in 1877. A member of a pioneer West Florida family, he was the son of Daniel L. and Mary Attaway McKinnon. Upon being awarded the degree of Doctor of Medicine in 1906 by the Tulane University of Louisiana School of Medicine, he returned to Marianna where he engaged in the private practice of internal medicine for nearly half a century.

Locally, Dr. McKinnon was active in civic affairs. He was elected repeatedly to the City Council and served on the Chamber of Commerce. He was a Mason, a Rotarian and an Episcopalian.

Dr. McKinnon was a life member of the Jackson-Calhoun County Medical Society, the Florida Medical Association and the American Medical Association. He had served many times as president of his county medical society and also on numerous committees. Early in the century he was instrumental in obtaining Marianna's first hospital, and he was also most active in promoting the present Jackson Hospital. He was chief of staff of the Jackson Hospital from the time of its opening in 1941 until his death.

Survivors include the widow, Mrs. Pearl Pittman McKinnon, and one daughter, Mrs. John Granger, both of Marianna; one son, Dr. D. A. McKinnon, Jr., of the Lovelace Clinic, Albuquerque; one brother, Francis T. McKinnon of Marianna; and two sisters, Mrs. Mae McKinnon Wilson of Marianna and Mrs. George E. Anderson of Washington, D. C. Seven grandchildren and one great-grandchild also survive.



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Information on request
Member American Hospital Association

Henry Boyleston Cordes

Dr. Henry Boyleston Cordes of Frostproof died on March 30, 1953, in the Lake Wales Hospital after suffering a heart attack a few weeks previously. He was 65 years of age and had been in failing health for several years.

Dr. Cordes was born in Charleston, S. C., on June 13, 1887. He was graduated from the Emory University School of Medicine in Atlanta in 1915. Entering World War I in April 1917, he served in France as a captain in the Medical Corps.

In 1920 he located in Frostproof, where he engaged in the general practice of medicine until a short time before his death. Always active in civic and community affairs, he was a former member of the City Council and a past president of the Rotary Club. He was a member of the Episcopal Church.

On his sixty-fifth birthday, June 13, 1952, Dr. Cordes was honored by the city and surrounding community at a public gathering. It was stated on that occasion that he had been the attending physician at the birth of more than 2,000 babies.

Dr. Cordes was a member of the Polk County Medical Society and had for 30 years held membership in the Florida Medical Association. He was also a member of the American Medical Association.

In 1915, Dr. Cordes was united in marriage with Miss Alice Corbett, who survives him. Also surviving are one daughter, Mrs. Huey W. Nobles, and a grandson, Everett Gilbreath, both of Frostproof; one brother, L. S. Cordes, and two sisters, Miss Charlotte Cordes, and Mrs. P. E. Law, all of Jacksonville.

1953 Medical District Meetings

"A", Tallahassee	October 19
"B", St. Augustine	October 20
"C", Tampa	October 21
"D", West Palm Beach	October 22

Advertisement



From where I sit *by* Joe Marsh

Hear About the Electric Weather Predictor?

Squint Smith built up a reputation last month by predicting the weather. What he said usually came true.

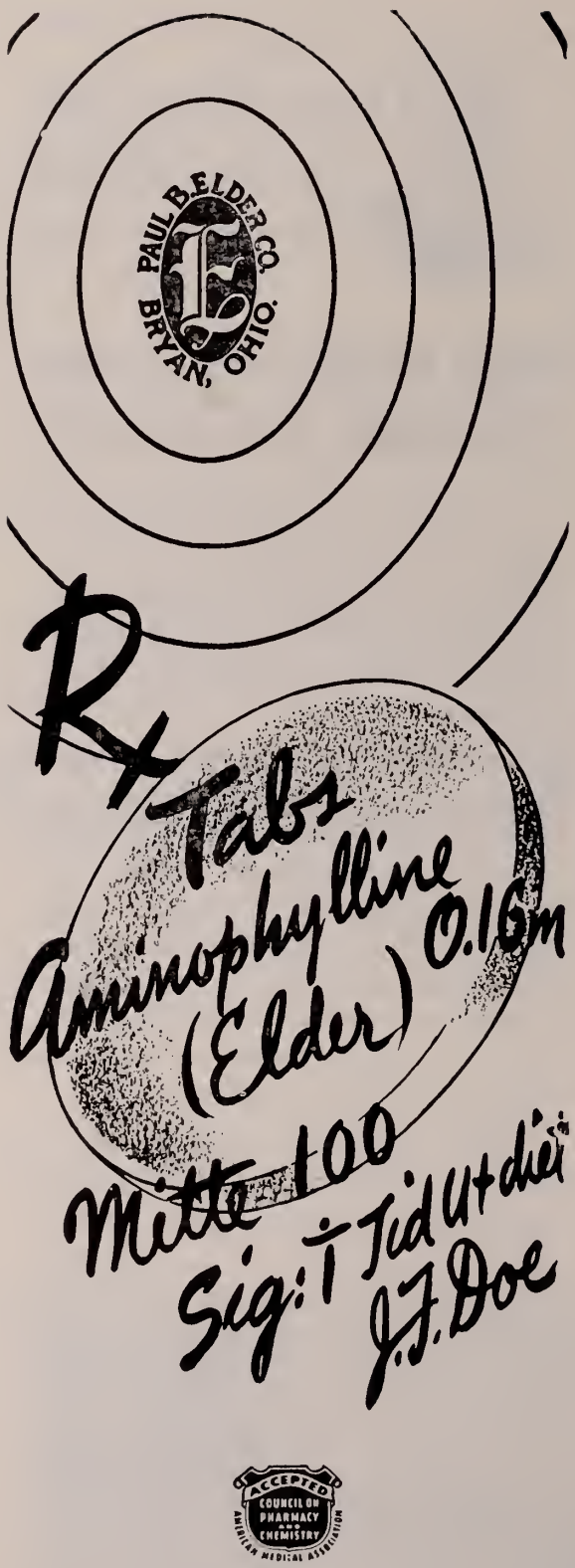
It got so that folks would sit around his little Antique Shop just to get his opinion.

Last Monday, though, he said he didn't know what the weather was going to be like next day. That surprised us and when we asked what happened, Squint said, "Slipped up on my electric bill and everything was turned off. I'll get to my radio again tomorrow though." Squint had been getting the weather reports over the radio—just like anyone else!

From where I sit, that's the way it goes with some "experts." They often don't have any more inside information than you can get for yourself. Like those who would tell people how to practice their professions . . . like those who "know" cider is the only *thirst-quencher. Far as I'm concerned, I'll take beer. But—I won't try to "predict" your choice for you.*

Joe Marsh

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Public Relations

Public relations is a good subject to think about because it is the least generally understood activity in organizational endeavor. The name in itself is misleading. It is accepted by many as a departmental function of a group — something every going concern employs in some way, a panacea function of its own and a desirable practice. Activities are labeled public relations as though the title identified the act as something beneficial, when, in fact, public relations is a cumulative result of a practice and its desirability is contingent upon whether whatever is practiced is good or bad. Hence, we arrive at the verdict of good public relations or bad public relations.

Just as the predominant thought direction of an individual shapes his character and controls the course he inevitably pursues, creating a definite impact of personality upon his immediate environment, so the prevailing attitude of a group is formulated by the predominant factors which emerge from the thinking of its members. This impact of an organization upon society is classified as its public relations.

Whether this is a successful impact or a regrettable one is not always obvious until the position of a group is jeopardized by an unfavorable impression built up in the public mind. The alarm goes out! The P. R. Kit is reached for

like a medicine chest and volunteers are briefed in emergency first aid. This Band-Aid® treatment is risky because the short course recruits who rush out to minister to public opinion find abrasions too deep and trauma too wide-spread for the surface therapy employed by persons who never think of the public except in nebulous form . . . people they do not know.

Since this P. R. Kit is vital and indispensable to every organization, industrial and civic as well as social, it bears out its versatility and testifies to its fundamental importance as a prerequisite ingredient to intelligent functioning by any group.

Like any quality it loses its value unless it is integrated into the whole. It can not be applied like a salve nor worn like a garland. To be effective it has to be interwoven throughout the group like the thin red thread which is found in quality rope. It is never obvious but its presence is looked for and appreciated by people who value top brand and plan to tie up with it.

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Q: How effective are these cigarette filters?

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1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

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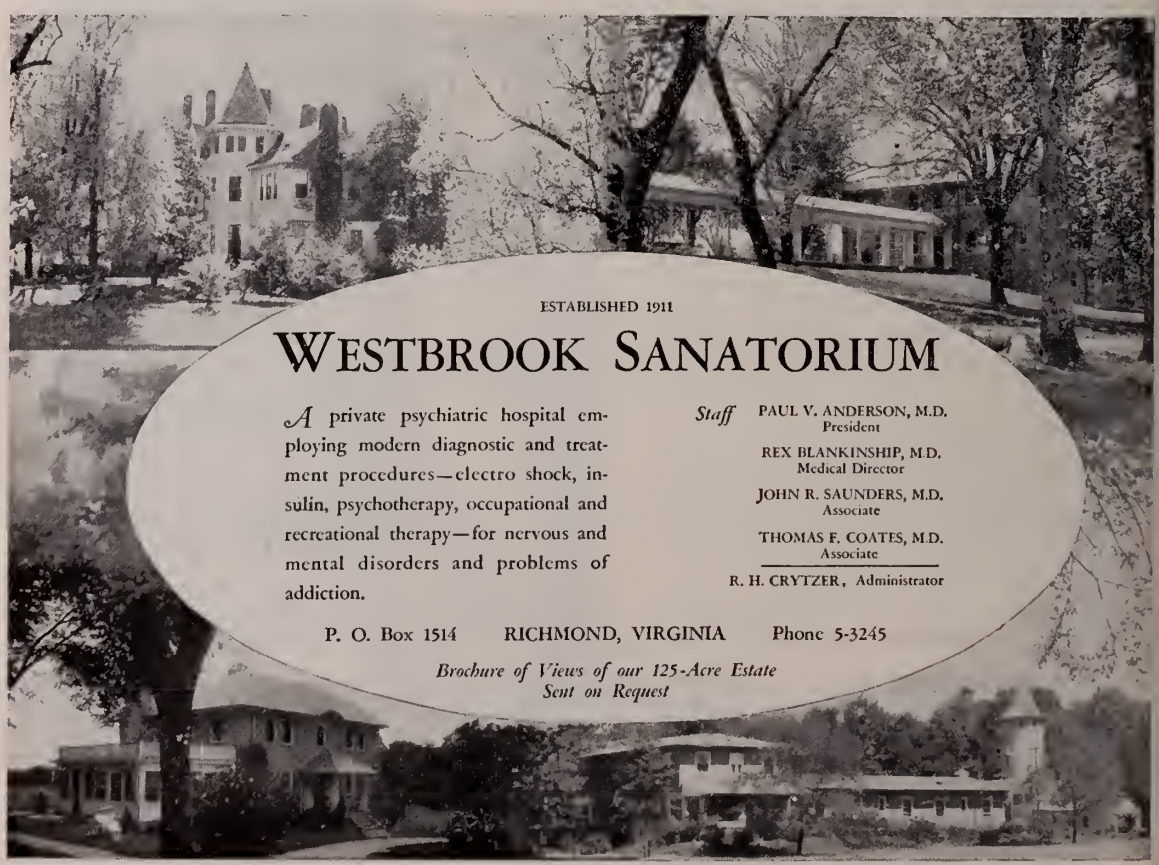
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ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
da Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
da Medical Districts	John D. Milton, Miami	Council Chairman	
Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, Oct. 19, '53
Northeast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, Oct. 20, '53
Southwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, Oct. 21, '53
Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, Oct. 22, '53
da Specialty Societies			
emy of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
gy Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
thesiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
ter, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
. and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
h Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
trial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
ology & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
nd Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
hal. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
pedic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Oct., '53
ologists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
tric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	Miami, Oct. 6, '53
ologic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	Hollywood, Apr. 25, '54
ological Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
gical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
da—			
sic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 7, '53
od Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
ue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
ue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
ncer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
nical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
ntal Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
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spital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
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armaceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
blic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, Oct. 22-24, '53
udeau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
berculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	
oman's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers, Jr., Cocoa	Hollywood, Apr. 25-27, '54
rican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
hern Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, Oct. 26-29, '53
ama Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
gia, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
Hospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
heastern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
heastern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
heastern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
Coast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct., '53

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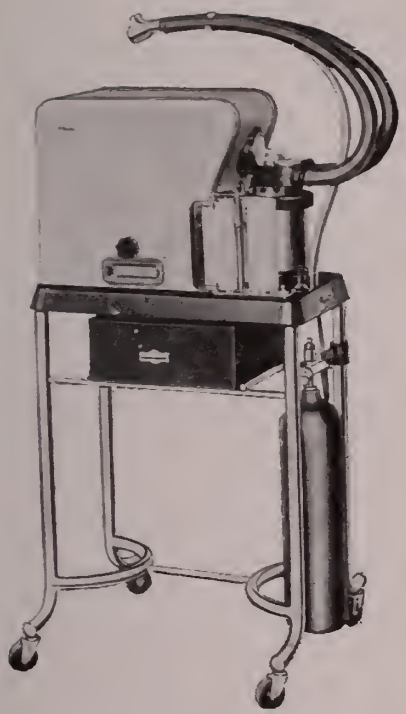
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					TOTAL	PAID	
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	24	
	Escambia **Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	91	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	100%	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia **Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	15	11	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	60	55	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D., Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
	Taylor **Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	100%	253
C	Alachua **Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Winston L. Summerlin, M.D. 111 S. W. 3rd St. Gainesville	2nd Tuesday 8:00 P.M.	44	42	
	Duval **Clay*	W. W. Rogers, M.D. 962 Main St. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	258	228	
	Marion **Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	27	100%	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	100%	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	15	100%	
D	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Knester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	27	26	
	Lake **Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	29	28	B-4-55 Thomas C. Kenaston, M.D., Cocoa
	Orange **Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	172	169	
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia **Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	76	694
E	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	177	170	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	20	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D., St. Petersburg
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	205	203	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	44	
F	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	100%	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	29	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	93	618
G	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	124	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	17	16	
H	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	96	94	D-8-55 Russell B. Carson, M.D. Fort Lauderdale
	Dade	Ralph W. Jack, M.D. 1700 Biscayne Blvd. Miami	Walter W. Sackett, Jr., M.D. 2500 Coral Way Miami	1st Tuesday 8:30 P.M.	634	576	
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	13	894

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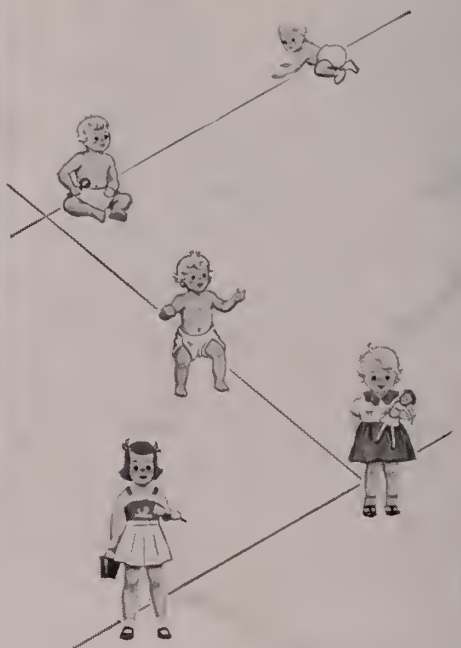
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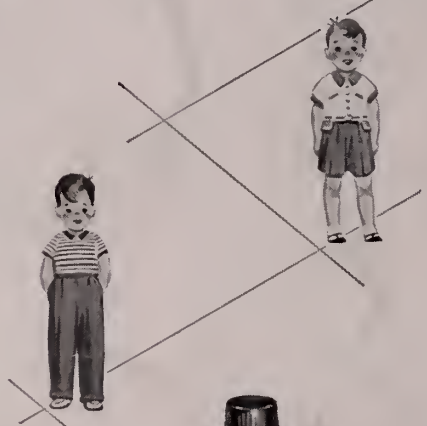
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John D. Milton

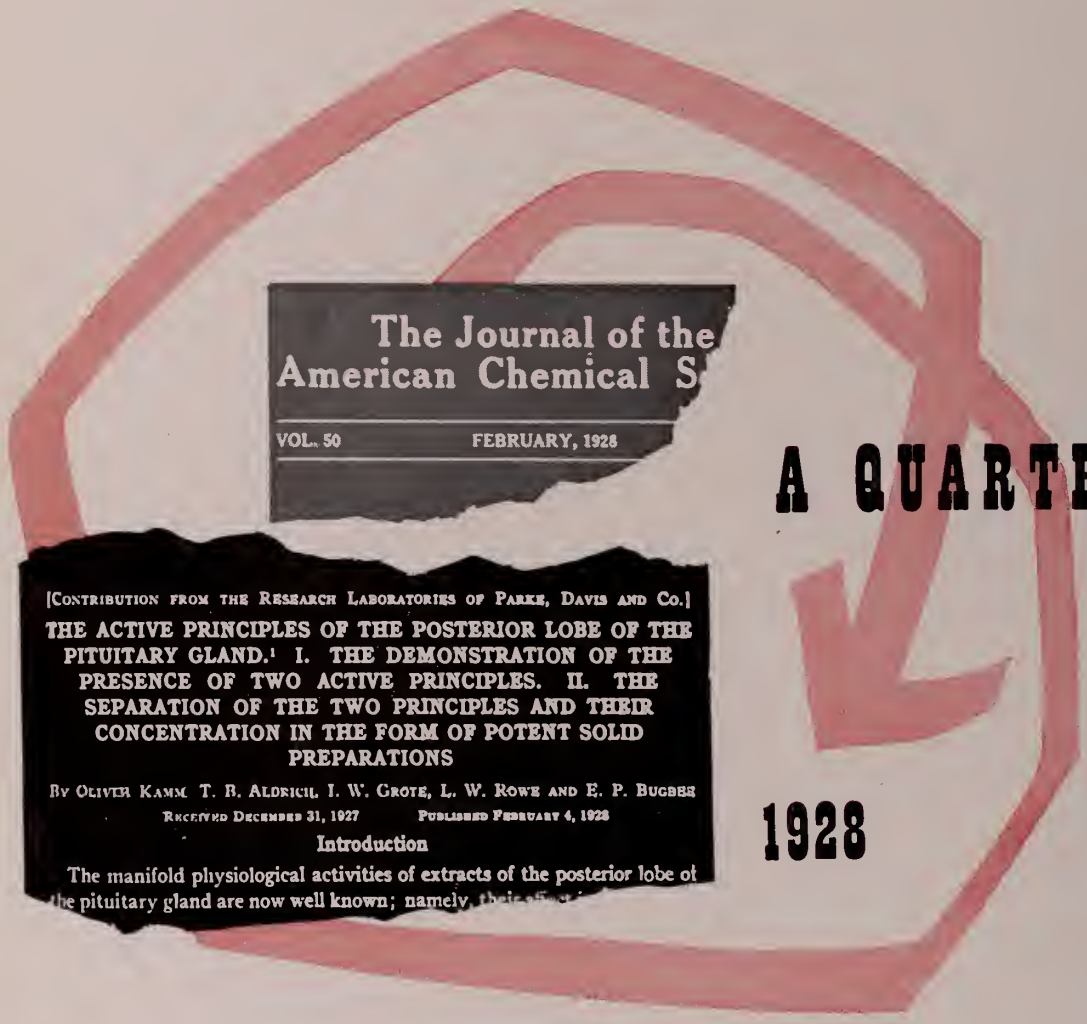
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Louis M. Orr

Program Medical District Meetings
October 19-22, 1953

OFFICIAL PUBLICATION OF THE
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The Journal of the American Chemical S

VOL. 50 FEBRUARY, 1928

A QUARTER OF A

1928

[Contribution from the Research Laboratories of Parke, Davis and Co.]

THE ACTIVE PRINCIPLES OF THE POSTERIOR LOBE OF THE PITUITARY GLAND.[1] I. THE DEMONSTRATION OF THE PRESENCE OF TWO ACTIVE PRINCIPLES. II. THE SEPARATION OF THE TWO PRINCIPLES AND THEIR CONCENTRATION IN THE FORM OF POTENT SOLID PREPARATIONS

By Oliver Kamm, T. B. Aldrich, J. W. Grote, L. W. Rowe and E. P. Bugbee

Received December 31, 1927 Published February 4, 1928

Introduction

The manifold physiological activities of extracts of the posterior lobe of the pituitary gland are now well known; namely, their

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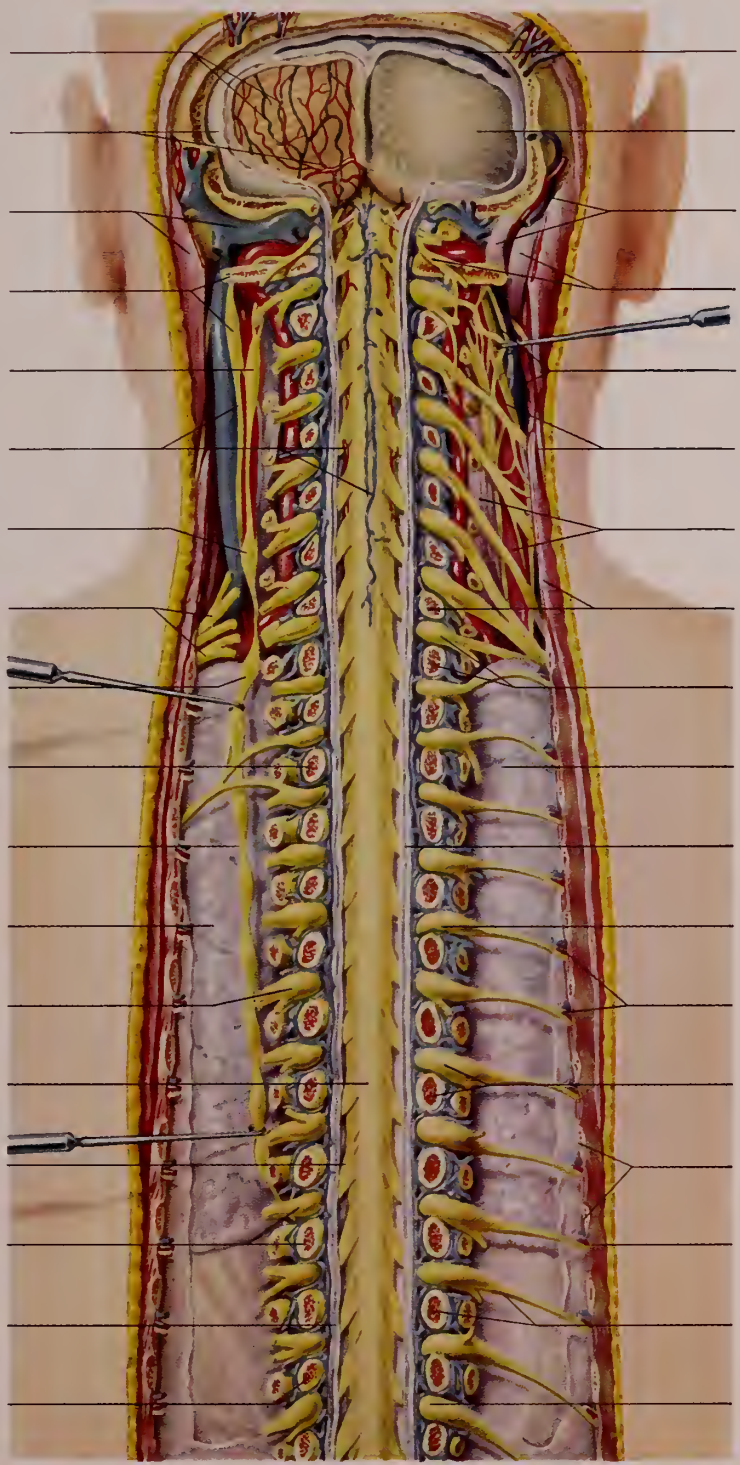
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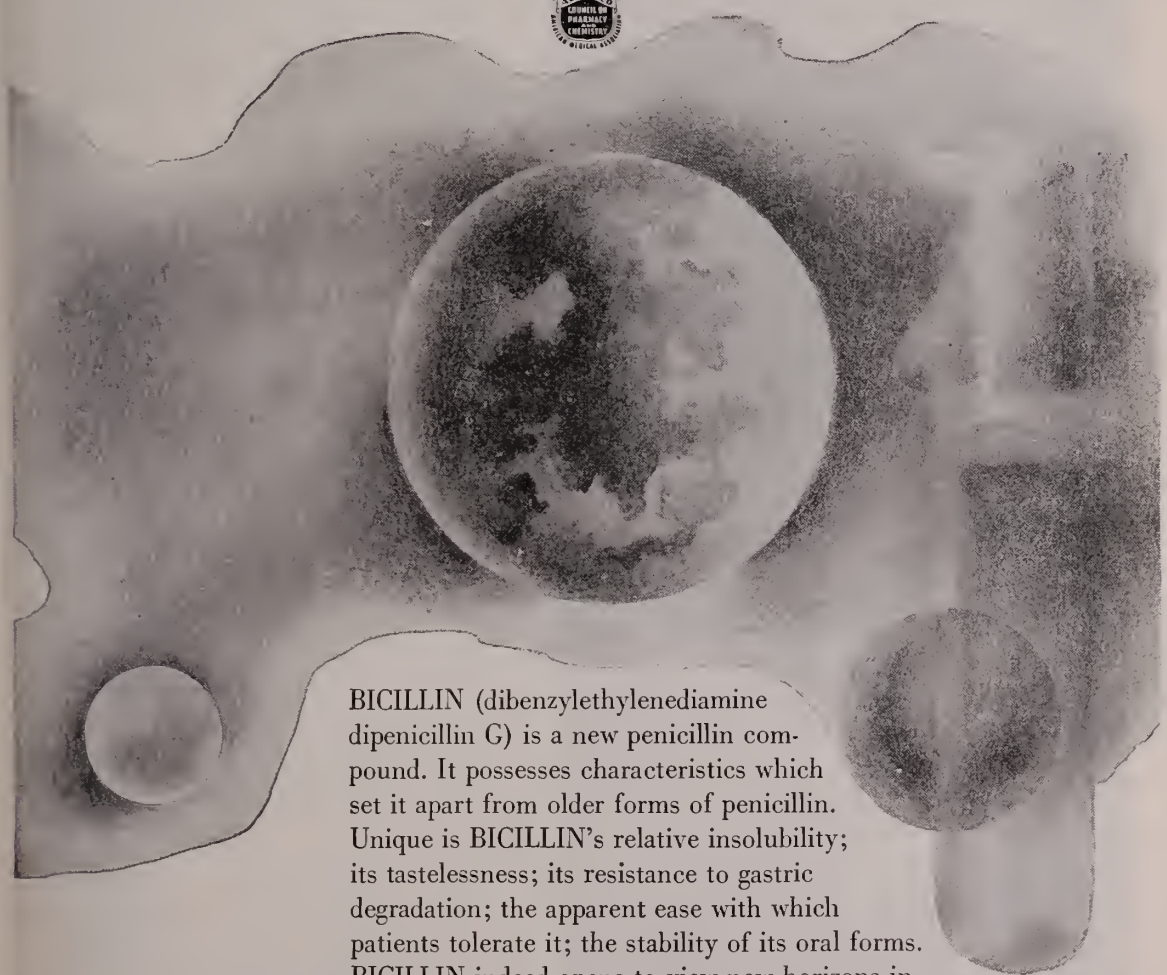
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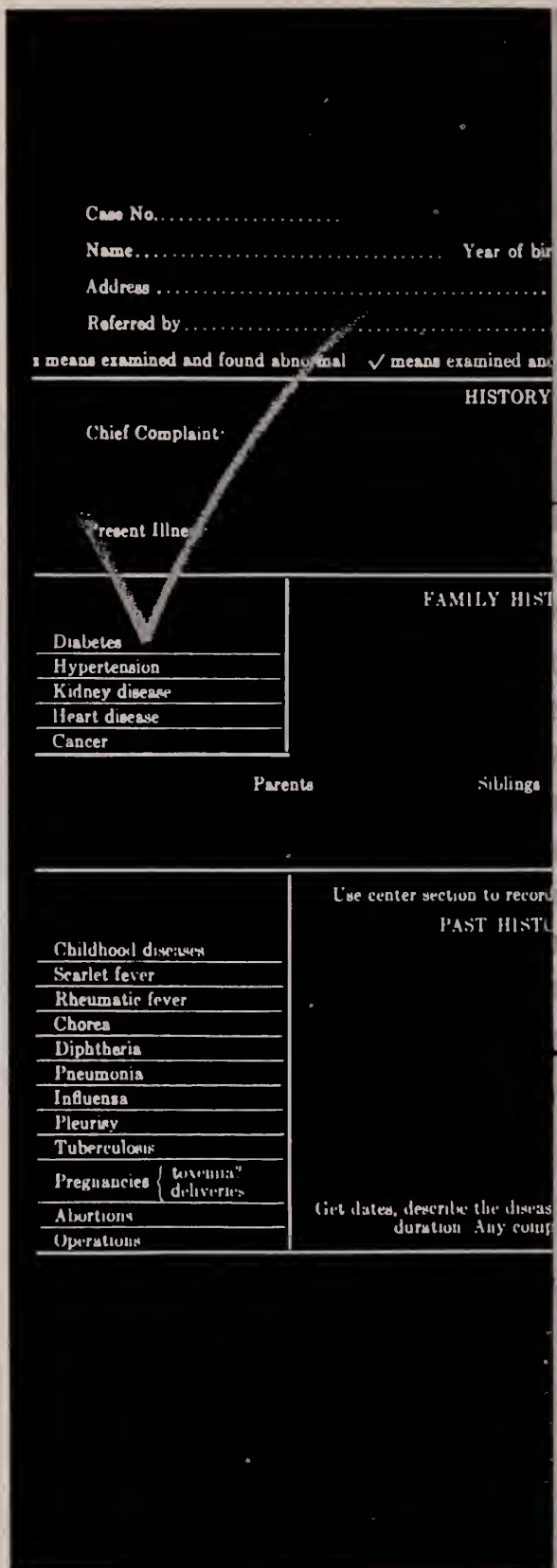


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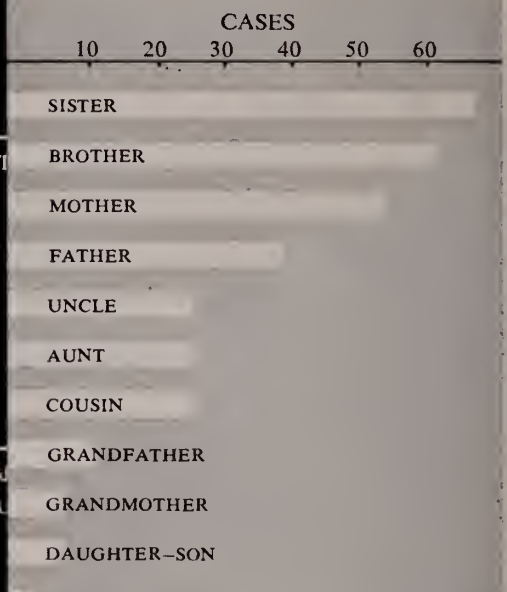
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1. Barach, J. H.: Diabetes and Its Treatment, New York, Oxford University Press, 1949, p. 38.
2. Allen, F. M.: Diabetes Mellitus, in Piersol, G. M., and Bortz, E. L.: Cyclopedia of Medicine, Surgery, Specialties, Philadelphia, F. A. Davis Company, 1951, vol. 4, p. 505.

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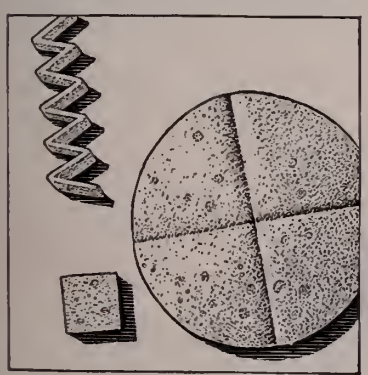
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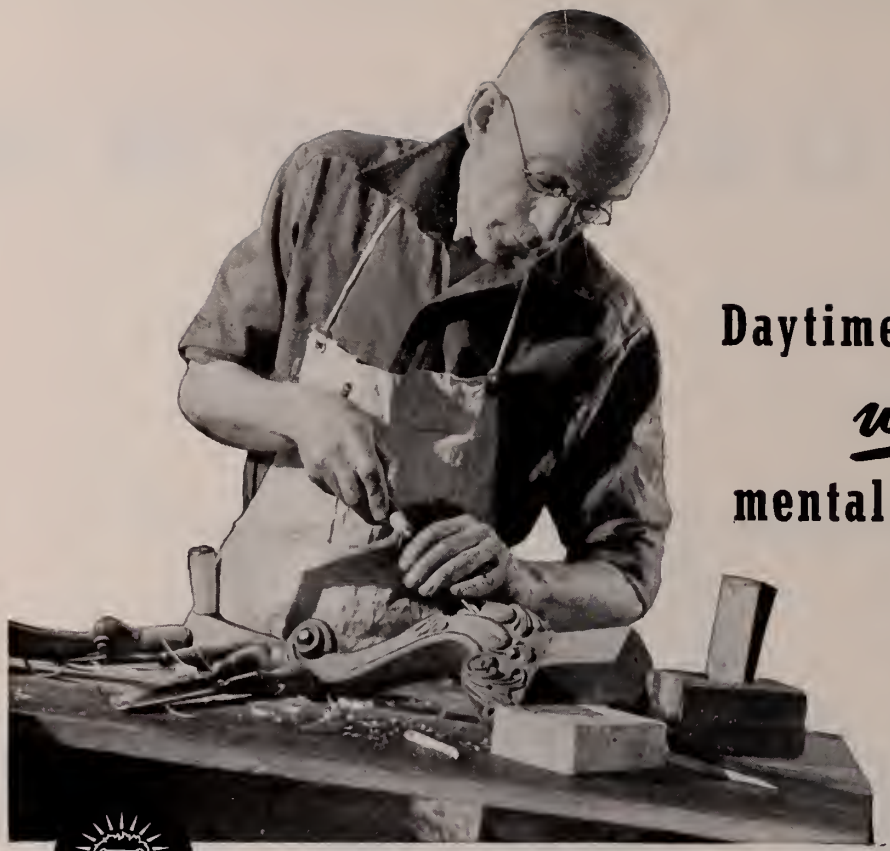


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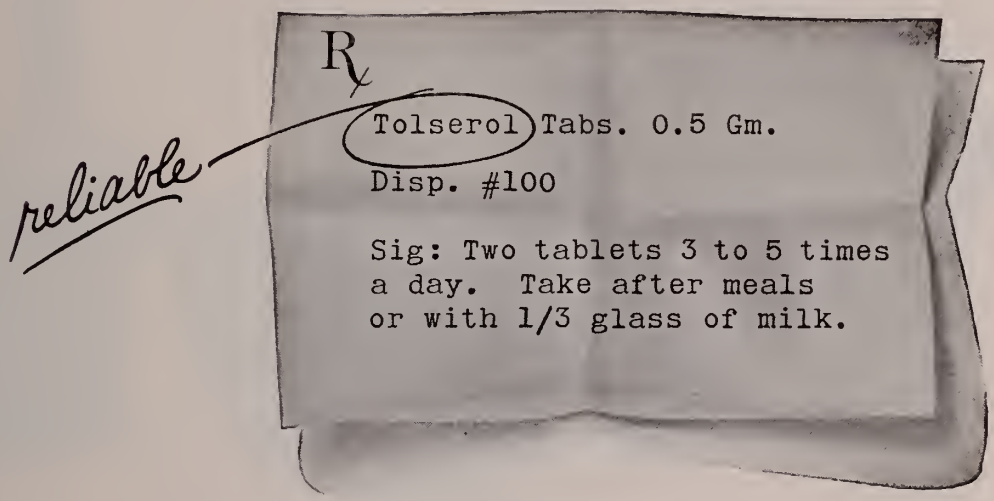
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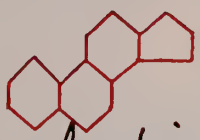
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1. Ferguson, C., and Miller, C. D.: J. Urol. *67*:762 (May) 1952.
2. Trafton, H. M., and Lind, H. E.: Ibid. *69*:315 (Feb.) 1953.
3. Blahey, P. R.: Canad. M. A. J. *66*:151 (Feb.) 1952.

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(1) Cheadle—*Artificial Feeding and Food Disorders of Infants.* Sixth Edition (1906)

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Primary Sites of Pathology and Indications

1. EYE—Inflammatory eye disease. **2. NOSE**—Intractable hay fever. **3. LARYNX**—Laryngeal edema (allergic). **4. BRONCHI**—Intractable bronchial asthma. **5. LUNG**—Sarcoidosis. **6. HEART**—Acute rheumatic fever with carditis. **7. BONES, JOINTS, AND BURSAE**—Osteoarthritis; Rheumatoid arthritis; Rheumatoid spondylitis; Acute gouty arthritis; Still's disease; Psoriatic arthritis; Bursitis. **8. SKIN AND CONNECTIVE TISSUE**—Pemphigus; Disseminated lupus erythematosus; Scleroderma (early); Dermatomyositis; Atopic dermatitis; Exfoliative dermatitis; Dermatitis venenata (*e.g.*, poison ivy); Dermatitis medicamentosa. **9. ADRENAL GLAND**—Congenital adrenal hyperplasia; Addison's disease; Following adrenalectomy for hypertension, Cushing's syndrome, and neoplastic diseases. **10. BLOOD, BONE, AND MARROW**—Allergic purpura; Acute leukemia* (lymphocytic or granulocytic); Chronic lymphatic leukemia.* **11. LYMPH NODES**—Lymphosarcoma;* Hodgkin's disease.* **12. ARTERIES AND CONNECTIVE TISSUE**—Periarteritis nodosa (early). **13. KIDNEY**—Nephrotic syndrome, without uremia (to induce withdrawal diuresis). **14. VARIOUS TISSUES**—Angioneurotic edema; Serum sickness; Sarcoidosis; Drug sensitization; Waterhouse-Friderichsen syndrome.

*Transient beneficial effects.

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Acute Obstetric Conditions Requiring Laparotomy

An Analysis from the Department of Obstetrics and Gynecology At Jackson Memorial Hospital

JOHN D. MILTON, M.D.
MIAMI

Jackson Memorial Hospital in Miami is the county hospital, with both private and staff cases. There are 32 physicians on the Obstetrical and Gynecological Service representing medical schools from the North, East, South and Midwest; 20 of them are certified by the American Board of Obstetrics and Gynecology. The management of private cases reflects the many different opinions taught at the several medical schools. Staff cases are handled by an established routine; this uniformity of action makes it possible to evaluate the different procedures in respect to results so that changes can be made if necessary for improvement. The obstetricians and gynecologists of our Miami group work in close harmony and have frequent consultations, which benefit both the patient and the department and result in an unexcelled service.

The Staff Service at Jackson Memorial Hospital acts in a consulting capacity to the Health Department Prenatal Clinics, and also to several of the smaller hospitals in the area. The moment any complicated obstetric case is detected in one of these hospitals, the patient is transferred immediately to Jackson Memorial Hospital. This practice increases the number of our emergencies.

The statistics as analyzed here bring to light the amount of work that was accomplished over a two year period in the Department of Obstetrics and Gynecology at Jackson Memorial Hospital. The analysis also shows the frequency of complications which required laparotomy. This information is grouped in two major headings: (1) cases in the first trimester and (2) cases in the third trimester.

Read before the Florida Obstetric and Gynecologic Society, Midwinter Meeting, St. Petersburg, Dec. 1, 1951.

Table 1.—Obstetric and Gynecologic Cases from March 16, 1949 Through March 15, 1951

Obstetric Cases	6,562
Gynecologic Cases	2,823
Total	9,385

The report of the obstetric emergencies covers a period from March 16, 1949 through March 15, 1951. During this time there was a total of 6,562 cases on the Obstetrical Service and 2,823 on the Gynecological Service (table 1). One might wonder why gynecologic cases are used in an obstetric report. They are included because all ectopic or tubal pregnancies and abortions whether complete, incomplete or threatened were entered on Gynecological Service.

Table 2.—Types of Cases Encountered in First Trimester

	Number	Percentage to Number of Discharges
Incomplete abortion	414	4.40%
Ruptured tubal pregnancy	49	.53%
Unruptured tubal pregnancy	11	.10%

Of 60 tubal pregnancies, 49 were ruptured and 11 unruptured. They occurred in 8 private patients and 52 staff patients. In more than half

of the ruptured ectopic pregnancies the patients were first seen in shock of more or less profound nature. They were given massive transfusions until the blood pressure was returned to a fair or normal level. It is not deemed wise to move these patients from one place to another after a diagnosis of ruptured ectopic pregnancy has been made. In every possible case, therefore, the patient was prepared for surgery while in the emergency room and only then removed to the operating room.

Success in handling these cases was based on accurate diagnosis with ample blood for the patient and immediate laparotomy. The diagnosis was based mainly on the following criteria:

Table 3.—Subjective Symptoms

1. Missed or delayed menstrual periods
2. Abnormal vaginal bleeding, irregular, free or scant
3. Acute episodes of pain in either lower quadrant of the abdomen, especially on urination
4. Fainting accompanied by pains
5. Shoulder pain
6. Urgency to defecate

Table 4.—Objective Symptoms

1. Dropping blood pressure
2. Rising pulse
3. Low blood count
4. Marked rigidity and tenderness of the lower portion of the abdomen
5. Rebound tenderness
6. Soft mass in adnexa on either side
7. Occasional bulging of the cul-de-sac
8. Excruciating pain on manipulation of cervix

We regard the factors listed in table 4 quite as diagnostic as culdoscopy or posterior colpotomy. In my opinion excruciating pain on manipulation of the cervix is one of the most important. In the cases in which a culdoscopy was performed, the diagnosis was only approximately 50 per cent accurate. We have not found culdocentesis as accurate as Beacham and Beacham,[1] who had only "six unwarranted laparotomies out of 500 cases." Postoperative recovery in practically every instance was rapid and uneventful with the exception of the 1 fatal case which is reported here.

Report of Case

L. M. A., a Negro woman, aged 32, was treated for two weeks at another hospital for a proved pelvic inflammatory disease. She improved greatly and was discharged. Two weeks later she was admitted to the Jackson Memorial Hospital after an acute attack of pain in the right lower quadrant of the abdomen. Because of obesity no masses could be outlined. There was moderate pain in the lower portion of the abdomen, but no rebound tenderness. No pain was elicited on vaginal examination, and movement of the cervix caused no great discomfort. The patient was kept under observation for 24 hours and then examined under anesthesia, but no additional information of importance could be determined.

On March 13, 1951 the red blood cell count was 3.2 million with white blood cells 8,200 and hemoglobin estimation 59 per cent. On the following day the count was red blood cells 3.1 million and white blood cells 7,200; the hemoglobin estimation was 55 per cent.

Death occurred suddenly three hours after the examination under anesthesia on March 14. At autopsy, a 4 month fetus was found extruding from the right fimbriated end of the tube. The cause of death was intra-abdominal hemorrhage. An absolute diagnosis was not made, but laparotomy was planned the next day. Immediate laparotomy might have prevented this death.

Table 5.—Types of Cesarean Section Chosen

	Private Obstetrics	Staff Obstetrics	Surgery and Genl. Prac.	Total
Classical section	85	18	37	140
Transverse cervical	96	28	2	126
Porro's operation	2	3	0	5
Extraperitoneal	1	1	0	2

The types of cesarean section were divided into three groups (table 5). This classification was made for the purpose of comparing the results of private obstetrics with those of staff obstetrics and those of the general practitioners and surgeons.

General practitioners and general surgeons performed 39 sections, 94.8 per cent classical and 5.2 per cent low cervical. In private obstetrics there were 184 sections with 46.19 per cent classical and 52.19 per cent low cervical, 1.08 per cent Porro's operation and 0.54 per cent extraperitoneal. Of 50 sections in staff obstetrics 36 per cent were classical, 56 per cent low cervical, 6 per cent Porro's operation and 2 per cent extraperitoneal.

The number of low cervical sections is not as high as in other institutions. I think this difference is occasioned by the fact that up until recently a majority of the sections in Miami were performed by the classical routine. The percentage, therefore, will possibly remain elevated for four or five years owing to possible repeat sections on girls who have been previously subjected to section by the classical routine. The number of classical sections, however, should be decreasing while low cervical sections are increasing.

Table 6.—Indications for Elective Cesarean Section*

Indications	Number of Cases
Previous cesarean section	95
Cephalopelvic disproportion; no previous section	60
Fibrosis of cervix; cervical dystocia	10
Elderly primipara	10
Two previous long labors	2
Previous multiple vaginal repairs	2
Prolonged labor; uterine inertia	4

*There were four additional cases of elective section that through some oversight were not entered on Indications for Elective Section.

Table 6 presents the indications for elective sections. The outstanding indication is that of previous cesarean section, and from this one may surmise that we subscribe to the old adage "once a section, always a section." This is true. Since these indications are in practically the same proportions as observed in other parts of the country, they deserve no particular comment.

Table 7.—Indications for Emergency Cesarean Section

Indications	Number of Cases
Placenta previa	29
Abruptio placentae	11
Toxemia	10
Uncontrolled or severe diabetes mellitus	7
Rh-negative mother. Immunized	6
Long labor. Fetal distress	6
Abnormal presentation: brow; occiput posterior with obstructing fibroids; face; transverse; prolapsed arm	5
Rheumatic heart disease	3
Retroperitoneal hemorrhage; hydrocephalic fetus; obstruction fibroids; schizophrenia; detached retina, etc.	8
Ruptured uterus	1

Placenta Previa and Abruptio Placentae

Placenta previa and abruptio placentae were handled almost routinely the same as far as treatment was concerned. The management of these cases was dependent "upon two things, condition of the cervix and the rate of bleeding."[2] The criteria for laparotomy, therefore, in these two entities were a long, hard, undilated cervix and the patient not in labor or in early labor. Should the patient be in active labor with the cervix well dilated, soft and effaced, vaginal delivery would be carried out. Placenta previa and abruptio placentae represented 40 cases or 14.6 per cent of the total number of cases of cesarean section (table 7). This proportion is rather high when compared with that of an institution such as the New York Lying-In Hospital,[3] which had a rate of only 8.9 per cent of all the cesarean sections performed there during 1950. Twenty-eight babies were salvaged, 8 were stillborn, and there were 4 neonatal deaths.

In this group there was 1 maternal death in the series presented here. A young multigravida in the last trimester of pregnancy was admitted in shock with failing fetal heart and severe abdominal pain. A diagnosis of abruptio placentae was made, and an emergency cesarean section was performed. The patient expired on the table. At autopsy, it was found that an unclassified tumor of a horseshoe kidney had eroded a vessel causing a massive retroperitoneal hemorrhage. It was concluded that the cause of death certainly was connected in no way with the pregnancy. Since the patient was moribund when placed on the operating table and died in profound shock just as the procedure was starting, her death should not be charged against the attempted cesarean section.

Toxemia

In 10 cases of toxemia there was no response to any type of conservative treatment. The pregnancy, therefore, was terminated by cesarean section, it being near term in all instances. In this group there were 2 fatalities.

The reports of eight different hospitals[3-10] were reviewed, and the percentages for toxemia were a high of 10.26 per cent of all cesarean sections and a low of 1.6 per cent. The record of this series was third from the lowest with 3.6 per cent.

Rh-Negative Mother — Immunized

Approximately 154 Rh-negative mothers were immunized; 22 were delivered of stillborn babies. Of the 132 immunized mothers with viable babies, 71 had a titer of less than 1:32, and 61 mothers had a titer above 1:32; 26 of these babies or 44.4 per cent required exsanguination transfusions. Six mothers were subjected to cesarean section as labor could not be induced medically. In these cases the pelvic measurements were borderline, and the titers ranged from 1:64 to 1:128.

Ruptured Uterus

Ruptured uterus is listed once under indications, but actually in this series there were 3 cases, in all of which the rupture was spontaneous. In all 3 cases a living child and mother were obtained. Briefly, the histories were as follows:

The first patient had had one previous pregnancy and a classical cesarean section. With this pregnancy she had no labor. An early rupture of the uterus was found at elective cesarean section near term.

The second patient had had one previous pregnancy and a classical cesarean section. She was in mild labor about four hours before reporting to the hospital. The diagnosis of ruptured uterus was made when she was first seen in the hospital, and an emergency cesarean section was performed, a living child being obtained.

The third patient had had four previous pregnancies and four classical cesarean sections. The patient was posted for an elective cesarean section. Rupture of the uterus occurred while she was en

route from her room to the surgical suite. A cesarean section hysterectomy was performed successfully with a living child and mother resulting.

Cosgrove[11] and Schmitz,[12] not heeding the adage "once a section, always a section," recommended watchful waiting and "trial labor."

If my associates and I had delayed and had not been on the alert in the cases in this series, in my opinion there might have been undue complications.

Our experience bears out the contention that uterine rupture may come either before labor or in early labor. I believe, therefore, that if one is on the alert, he will be able to pick up indications of pending rupture of the uterus. This is the ideal time for laparotomy. After rupture of the uterus immediate laparotomy is the essence of lowering maternal and infant mortality. Beacham and Beacham[13] stated: "When rupture does occur, there is definite correlation between mortality and the time interval from rupture to laparotomy."

Abdominal Pregnancy

One case of abdominal pregnancy was seen during this two year period. In this case the pregnancy was carried to full term, and the case is worthy of a full report, but time does not permit. It was a private case of Fox and Chrisman[14] and the diagnosis was made fairly early in pregnancy. After close observation over a period of approximately five months after the diagnosis of abdominal pregnancy, the patient was laparotomized, and a live baby was obtained. Since the placenta was densely adherent, no attempt was made to remove it. The abdomen was closed without drainage. Later this patient was returned to the hospital because of a fast-growing mass. When the abdomen was opened, an immense cyst was found around the site of the placenta, and a portion of the cystic wall was removed. The abdomen was closed, and the patient made an uneventful recovery. There was complete resolution of the mass after five or six months. This ratio would be 1 to 9,385 cases, and at the time was the three hundred seventeenth case of a living mother and baby in the world literature.

Summary

The acute obstetric conditions at Jackson Memorial Hospital over a two year period are analyzed, and the statistics are compared with those from seven other hospitals. Incidentally, these conditions occurred during the first two years of our approved residency.

There was 1 death in the series of 60 ectopic pregnancies. Operative intervention might have prevented this death.

There was a 4.1 per cent cesarean section rate in over 6,000 obstetric cases. The records of only one of the hospitals studied showed a lower cesarean section rate.

Three deaths occurred in the 86 cases of emergency cesarean section. One death was due to massive retroperitoneal hemorrhage from an eroded vessel of a horseshoe kidney, giving a corrected mortality rate of 2.3 per cent.

There were no deaths in the 187 cases of elective cesarean section.

In 3 cases of full term pregnancy with ruptured uterus the patients were operated on without a single maternal or infant death.

There was 1 case of full term abdominal pregnancy with laparotomy resulting in a living mother and baby.

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701 Huntington Building.

MEDICAL DISTRICT MEETINGS

Tallahassee, Oct. 19, 1953 — **Tampa, Oct. 21, 1953**

St. Augustine, Oct. 20, 1953 — **West Palm Beach, Oct. 22, 1953**

Some Unsolved Problems of Industrial Surgery

Henry C. Marble, M.D.
BOSTON

The last four decades have brought about a great change in the whole problem of industrial surgery. There are, however, some subjects which are as yet unsolved. There is still need for careful and painstaking clinical and laboratory research in three major fields.

The first is the problem of the low back strain.

Second is the problem of un-united fractures.

And third is the problem of causalgia and its allied conditions.

Progress

But before I go into these, I must explain to you that I am not unmindful of the great advances made in surgery during the past four decades.

The first of these decades was the golden era of abdominal surgery. The teaching concerning the care of the injured was neglected. The injured patient was handed down from the senior surgeon to the junior, and often to the house staff, because, at that time, there seemed to be greater appeal in the surgery of the abdomen and its contents.

The surgeons who entered the first World War were poorly equipped, both by training and by teaching, to cope with battle casualties that came before them, but they learned, and learned fast.

After the war came a great change. The speeding automobile and new accident losses began to fill the wards with injured patients. A new group of young surgeons became interested in trauma and its problems.

At the same time other branches of surgery began to expand, chest surgery, neurosurgery, orthopedic surgery, genitourinary surgery. The expansion was truly wonderful and awe-inspiring. The technician in the operating rooms improved. The knowledge of aseptic technic advanced. Interest in anesthetics grew until we now have a truly superb group of doctors interested in this problem. The modern anesthesiologist is a vital and all-important partner in the surgical team.

We learned new ways to control hemorrhaging and keep the loss of blood to a minimum.

All of this progress took place in the second and third decades.

Then came new means of controlling infection, first with sulfonamides and later with antibiotics. What a pair of weapons was put in the hands of the surgeon.

Thereafter came the second World War. Again all of our resources were marshalled to care for these new war casualties. The entire knowledge of the country was combined to give our best surgery to the injured. Now we had well trained surgeons who understood the management of trauma. We had good anesthesia. We had methods of controlling sepsis. We had means of hemostasis. And lastly, we had an understanding of the reaction of the body to trauma. In other words, we had blood, plasma and saline to furnish replacements and to effect physiologic balance. The results speak eloquently for themselves.

Since the war the literature has been filled with laboratory studies as well as clinical reports pointing out the value of an understanding of the knowledge of physiologic balance. The application of this knowledge to the whole field of trauma is making itself known day by day.

Unsolved Problems

But still there are problems unsolved in the world of industrial surgery. I want to bring them before you in the hope that they may stimulate interest in clinical and maybe laboratory research.

1. The first is the problem of the low back strain. Every doctor has his quota of this perplexing and persistent problem. There are thousands of queries as yet unanswered. What is the etiology? What is the pathology? What is the diagnosis? What is the treatment? So far we have no answers to any of these questions. We must confess ignorance of the pathology. We do not know the diagnosis. We have no special treatment.

Surgeon-in-Chief, Chelsea Memorial Hospital, Boston.
Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 27, 1953.

What do we know? The identical syndrome can come from minor or major trauma. The symptoms vary tremendously. The life history extends from a few days in some to years in others. We do know that 80 per cent of the patients lose no time from work. We do know that 15 per cent are well in six weeks, and the remaining 5 per cent may be out of work for months and even years.

Let us interrupt with one ray of hope. In certain cases in this group with sciatica it may, after study, be found that a protruded intervertebral disk is present. Surgical operation gives a satisfactory result in 60 per cent of these cases. The remaining 40 per cent are not cured. Should we be content with these results?

In the American Mutual Clinic in Boston, together with Professor Barr of the Harvard Medical School, we are carrying out a research, still in progress. We have developed a basis syllabus for study, in the hope that if enough doctors follow this procedure and record their results, we may gather sufficient data to aid in the understanding of these cases.

There is still a tremendous amount of work to be done. The solution seems far away.

2. Next is the problem of the un-united fracture. Let us use the fracture of the neck of the femur as a type.

In 1910 we all used the method of Whitman. His method was reduction followed by a plaster splint in bed. This was a standard procedure. You all know the results. Over 25 per cent of the patients died in the hospital, and of those who survived, about 30 per cent obtained good union.

Later the radiologist devised a method of taking a lateral exposure of the neck of the femur. Then at last we knew, which we did not know before, whether or not the fracture was reduced.

In 1927 came Smith-Petersen. He reduced the fracture as before, checking his reduction by a couple of roentgenograms, and then fixed the fracture by the use of an intermedullary pin. There was no plaster splint. The hospital morbidity was reduced. The care of the patient was simplified. Bed sores vanished. But although many patients walked out of the hospital, or obtained solid bone union, there was still a considerable group in whom the fracture failed to heal even with this improved treatment. There was either an un-united fracture, a dead head or a septic necrosis. These represent 30 per cent of the cases.

Here again is an unsolved problem. It deserves study and careful research.

3. And last, but not least, we have the neurologic problem of causalgia and allied conditions.

In 1864, just after the War Between the States, Dr. Weir Mitchell reported upon the cases treated by him at the United States Hospital for Nervous Diseases in Philadelphia, and associated with him were two surgeons named G. R. Morehouse and W. W. Keen. Together they published the results of their studies under the title of "Gunshot Wounds and Other Injuries of Nerves."[1] In this publication he described the condition that he called causalgia.

It is true that this had been previously described by Denmark[2] in 1813, who described the sensation of pain "as beginning at the extremities of the thumb and all the fingers, except the little one, and extending up the arm, to the part wounded. It was of a burning nature, and so violent as to cause a continual perspiration from his face. He had an excoriation on the palm of the hand, from which exuded an ichorous discharge. He could not bear to be touched without evincing additional torture. This was as described by one of my patients. In our wards, we found this remarkable form of skin disease associated, as a rule, with a very characteristic burning pain, which in most of the cases became at length the dominant symptom."

Dr. Mitchell described this syndrome as causalgia. The treatment he recommended was as follows: "Causalgia or burning pain; water dressing — a vast number of means were tried to ease or cure causalgia, but the one essential for comfort was the use of water-dressings which were unceasingly renewed, and the sufferers carrying a bottle of water and a sponge and keeping the part covered. I have never known a man afflicted with causalgia who did not learn very soon the use of this agent, and I never knew one who could be induced to exchange it for any other permanent dressing."

The prognosis he described as follows: "At the same time I may add, that in the interval of three or four years, the gradual change which may occur in the worst of these cases is so great and so beneficial that only a careful study of many of them, with a comparison made from my notebooks, could have induced me to credit the degree of restoration which time may bring about."

Here, then, was the report as published in 1864. Now, almost a century afterwards, I can find no change. Causalgia still exists. The treatment is the same as 100 years ago. No new treatment is available. The prognosis is unchanged. Does not this call for further study and research?

Let us not conclude on a pessimistic note. In 40 years wonderful advances have been made. The whole physiology and pathology of trauma are better understood.

We now can cope with most infections. But still there is a fertile field for clinical research.

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270 Commonwealth Avenue.

The Treatment of Post-Thrombophlebitic Changes in the Legs By Various Surgical and Conservative Means

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Thrombophlebitis in the leg following a surgical operation, parturition, or certain febrile illnesses, is one of the worst possible complications. Not only is there a possibility of fatal pulmonary embolism, but the sequelae which follow this condition are frequently accompanied by much suffering and disability. In the months and years following the occurrence of thrombophlebitis in the veins of the extremity, the veins commonly recanalize, but the valves have usually been destroyed by the thrombophlebitic process. These changes result in many cases in an increase in the venous pressure in the lower extremity, edema, pigmentation, and eventually ulceration of the leg. The extremities which are affected by this condition are subject to fungus infection, and are frequently attacked by streptococcal infection. As Homans[1] has emphasized, the fungus provides an opening through which the streptococci enter the tissues.

The results of treating the unfortunate victims of this disease by various surgical and medical means in a series of 48 cases form the basis of this paper. The follow-up period on these cases was from seven years to six months after the last operative procedure had been performed.

High Ligation of the Great Saphenous Vein Plus Ligation of Other Superficial Veins of the Leg

In 7 cases of the series, high ligation of the great saphenous vein was performed and in addition ligation of other superficial veins of the leg. In all but 1 case ulcers were present. In 2 cases excision and delayed grafting of the ulcer were performed, and in 1 of these the underlying bone was drilled. There was recurrence of the ulcer in 1 of these cases, with eventual healing by bilateral ligation of the superficial femoral veins plus bilateral subfascial ligation, and the lesion was healed one year later. In 1 case the ulcer had not recurred over a period of seven years, and in another over a period of six years. There were recurrences off and on in 1 case over a seven year follow-up period, but not for one year when the patient was seen in April 1953. The ulcers quickly recurred after healing in 1 case, and in 1 case the patient was not traced. Of the 6 cases with ulcers, the lesion is still present in 1 and healed in 4, though in 1 with much additional surgery; in 1 case it was not possible to trace the patient.

Ligation and Stripping of the Great and Small Saphenous Veins

In 3 cases treatment consisted of ligation and stripping of the great and small saphenous veins, in one instance bilaterally. In all the patients are well, but the follow-up time is only six to eight months after the operation. In 1 case after bilateral ligation and stripping of the great saphenous veins there has been no recurrence in the four and one half years since the operation. In 3 cases the procedure of choice was ligation and stripping of the great saphenous veins, combined with excision and grafting of the ulcer. In 2 of these cases

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healing was intact nine months and six months following the operation. In the third case the ulcer has persisted in a 76 year old man. In all except 1 of these 7 cases an ulcer was present and only in 1 has it persisted.

Ligation of the Common Femoral Vein and of the Great Saphenous Vein

In 1 case there was thrombophlebitis of the left leg with pulmonary embolism when the patient was first seen in August 1947. The common femoral and great saphenous veins were ligated, and the clot was sucked out of the femoral vein. The prothrombin time was prolonged by administration of Dicumarol. She was able to sew about four days a week until a year and a half ago. She now does housework, but it is necessary for her to lie down every hour or so while she works. There is diffuse swelling of the left leg, and she should be classified as a venous cripple. This will be the usual result of ligation of the common femoral and the great saphenous vein.

Bilateral High Saphenous Ligation with Subfascial Ligation of the Perforating Veins

In 1 case the surgical procedure was bilateral high saphenous ligation with subfascial ligation of all the perforating veins in the lower leg accompanied by the removal of the small saphenous vein. This operation was performed 15 months ago, and at the present time there is no swelling. There has been no recurrence of ulceration.

Unilateral Ligation of the Superficial Femoral Vein With Unilateral Ligation and Stripping of the Great and Small Saphenous Veins

In 15 cases of the series treatment consisted of unilateral ligation of the superficial femoral vein with unilateral ligation and stripping of the great and small saphenous veins. Varicose veins were the presenting symptom in 2 cases. Recurrent streptococcal infection was present in 1 case. In 7 of 12 cases with one or more ulcers on the legs there have been no recurrences. One ulcer failed to heal, but was eventually healed by lumbar sympathectomy, subfascial ligation, drilling of the bone, and repeated excision and skin graft. It has remained healed for almost two years at the present writing. Excision of the ulcer with skin grafting was performed one or more times in 3 cases. In 1 case two superficial ulcerations in the past four years have been healed easily. Repeated recurrent ulcerations about the malleoli and about the toes have occurred in 1 case with grafting repeatedly carried out. The patient does not cooperate in weight reduction, nor in any other way. The result is unequivocally bad in this case. In 3 cases of this group unilateral lumbar sympathectomy was performed, and in 1 case bilateral lumbar sympathectomy for Buerger's disease had been carried out before the ulcer developed. There was recurrence in 1 case following ligation of the superficial femoral vein and ligation and stripping of the great and small saphenous veins. A lumbar sympathectomy was then performed, and the ulcer seemed indolent following this procedure. The patient was advised to have the ulcer excised and grafted, but he refused to do so and discontinued coming to the office. Healing was effected, however, under his own treatment, and the lesion has remained healed without recurrence for four years and four months. In 1 case the diagnosis was doubtful. Ligation of the left superficial femoral vein with bilateral ligation and stripping of the great and small saphenous veins was performed. The patient was followed only eight or nine months, and I have not been able to get her to return for further examination.

In the case of ligation because of repeated streptococcal infections, the patient stated that he is unable to walk over three blocks without stopping to rest because of the occurrence of pain in his ankles. He has, however, had no further recurrence of streptococcal infection. One patient was treated who had had all of her pelvic organs removed a few years before. In this case ligation of the left superficial femoral vein with bilateral ligation and stripping of the great and small saphenous veins was done. Two years following the operation she was still complaining of pain about the left medial malleolus, and has stated repeatedly that she wishes she had not had the operation. It is inadvisable to operate upon female castrates except for very definite indications. In 12 of the cases in this group ulcers were present, and all except 2 are now healed.

Bilateral Ligation of the Superficial Femoral Vein Accompanied by Bilateral Ligation and Stripping of the Great and Small Saphenous Veins

In 8 cases (table 1) bilateral ligation of the superficial femoral vein accompanied by bilateral ligation and stripping of the great and small saphenous veins was performed. In 1 of these cases the surgical measures were bilateral excision and skin grafting of the ulcers, and later a subfascial ligation. In 6 of these cases the lesions are healed. In 3 of these 6, the patients wear compression bandages, which are gradually being

Table 1. — Bilateral Ligation of the Superficial Femoral Vein With Ligation and Stripping of the Great and Small Saphenous Veins

Cases	Age	Date	Result
E. W.	62	9/8/50	Last ulcer on left medial malleolus recently healed.
P. B.	42	8/17/51	No recurrence.
C. D. K.	56	7/24/50	Left lateral malleolar ulcer recurred, with healing following sympathectomy. No recurrence since November 1951.
J. C.	51	1949	Later subfascial ligation of veins of both legs and grafting. No recurrence since December 1951.
I. B.	61	9/21/51	No recurrence.
L. G.	37	10/18/49	Repeated minor recurrences about the left lateral malleolus. After left subfascial ligation there were still minor superficial recurrences. Lesions have been healed for the past two months.
E. H. C.	55	8/9/49	Recurrent ulcer in region of left medial malleolus. Night cramps have improved. Persistence of calf and knee cramps, which occurred before operation, and which occur after walking about 300 yards and are relieved by rest.
G. F. B.	40	12/15/50	Two small ulcers just over both left malleoli on Nov. 4, 1952.

discontinued. One of these patients will not stop wearing her bandages, although it is my impression that the bandage is no longer necessary. One patient repeatedly knocks the skin off the left medial malleolus, and the lesion is healed with difficulty. At present it is healed. There was recurrent ulceration in 1 of these cases which was healed in 1951 and has never recurred. In 1 case recurrent ulceration is now healed, but may recur. In 2 cases there have been recurrent ulcers over the left medial malleolus.

Ligation of the Inferior Vena Cava

The treatment of choice in 4 cases was ligation of the inferior vena cava. In 1 of these cases there was a leg ulcer before the inferior vena cava was ligated in 1945. An ulcer was excised and treated by delayed grafting in 1948, and the lesion healed. When the patient was seen six years after the caval ligation, no ulcer was present. She experienced a tired feeling in the calf of the leg on walking in sandy soil and had to stop about every block to rest her leg before she could go on.

An 80 year old patient who had repeated episodes of thrombophlebitis accompanied by pulmonary embolism was treated by ligation of the inferior vena cava. She died 18 months later of nephritis, and in the interim no changes indicating stasis developed.

A postabortal puerperal sepsis which was complicated by the occurrence of multiple pulmonary emboli was treated by ligation of the inferior vena cava and ovarian veins. When the patient was seen two years following the ligation, there was no edema of the legs, and she was three months pregnant.

A 59 year old patient, whose treatment with radium for carcinoma of the cervix was complicated by pelvic thrombophlebitis and pulmonary embolism, was treated by ligation of the inferior vena cava and both ovarian veins. There was no swelling of the legs until shortly before her death when severe swelling occurred, which was thought to be due to extension of the carcinoma into the pelvic tissues.

Unoperated Patients

Five patients refused operations. Two of these have had recurrent ulceration which was harder to heal than the first episode of ulceration. One patient wears an ace bandage at all times and has had no further difficulty. Two patients could not be traced. One patient, who had had 10 to 13 episodes of recurrent "erysipelas" prior to treatment, was effectively treated for his fungus infection with Desenex. In a four year follow-up period he has had no recurrences of the streptococcal infection of his leg. Four patients were treated by elevation of the legs, bandaging, control of weight, and control of fungus infection. None of these patients had an ulcer, and it was not believed that their symptoms were severe enough to justify an operation; they all improved. One patient, seen in 1946, was a young man who had had a wound during the second World War which had resulted in phlebitis and pulmonary embolism. Both legs were swollen, and his chief complaint was leg cramps. The leg cramps were controlled with Depropanex. The femoral vein was explored elsewhere a few months following this treatment, and it was noted that the left femoral vein contained a clot. No vein ligation was performed.

Comment

Ligation of the superficial femoral vein is probably helpful in these cases by creating an operative valve in the course of the femoral vein. This procedure also probably prevents the aimless swishing back and forth of blood in the femoral vein which occurs when this vessel is deprived of the action of its valves. The interruption of the superficial femoral vein which almost always occurs at the time of ligation cuts vascular sympathetic fibers and may prevent painful afferent stimuli from reaching the central nervous system and setting up vasospastic impulses. I am not sure that any of these explanations fully account for the beneficial results which sometimes occur.

It has been shown by several authors that ligation of the superficial femoral vein is followed by an increase in the venous pressure of the veins below the point of ligation. I do not think that this isolated laboratory finding should cause the surgeon to abandon this operation when it is indicated.

It is my present plan to ligate and strip the saphenous veins of the extremities first, and if sufficient improvement or cure cannot be obtained by treating these vessels, then to ligate the superficial femoral vein, or perform a subfascial ligation.

It is most important for these patients to follow a way of life which will aid the blood in returning from their lower extremities. They should lie down and put their legs straight up in the air for 30 minutes every three hours during the course of the day. If this is impossible, the elevation of the legs for 15 minutes every hour and a half is equally beneficial. The "coffee break," which is prevalent in much of industry at the present time, permits these patients to work and also to lie down for these rest periods. I encourage my patients to carry their lunch with them to work, and to lie down and put their legs up in the air while they eat. The most harmful activity for these patients is to stand for long periods of time. Walking is not as harmful as standing a long time. As is well known, the blood returns from the legs to the heart largely by the interaction of the muscles and the valves of the veins of the extremities. In standing, these muscles are not active, and they do not propel the blood back to the heart. Long-continued periods of standing are more harmful than shorter periods which are broken by putting the legs up in the air for a stated length of time. These patients should sleep with the foot of the bed elevated.

It is extremely important in post-thrombophlebitic conditions that fungus infection be eliminated from the body. In all the cases in this series this complication has been present. In all except 3 of the cases it still is present in spite of the efforts directed towards its eradication. If the surgeon is not sufficiently interested or adept at eradicating fungus infection, he should refer the patient to a dermatologist who will eradicate it if he wants to get the best results in the treatment of the post-thrombophlebitic leg. The use of the various fungicides is out of the scope of this paper. Sympathectomy aids in eradicating fungus infection probably by decreasing sweating.

Patients with the post-thrombophlebitic syndrome should never be discharged. They should be followed until their death. There is always a possibility that an ulcer which has been healed will recur. The ulcers are easier to prevent than they are to cure. These patients' legs should never be permitted to become swollen. The swelling can be eliminated by elevation of the extremity, or bandaging of the extremity. One or the other of these methods will almost always eradicate it. Swelling should be considered as a premonitory symptom of an ulcer.

I do not think that the correct operation for the post-thrombophlebitic syndrome has yet been developed. Some or all of the procedures mentioned, however, will be helpful in treating this condition.

Conclusion

A series of 48 cases is presented in which various manifestations of the post-thrombophlebitic syndrome have been treated by various surgical and medical measures. The results of treatment are enumerated.

Some of the practical points in the treatment of the post-thrombophlebitic syndrome are mentioned.

In 33 cases in which various operations were performed for ulcer, healing was effected in 25. In 1, the ulcer is now healed, but there have been frequent superficial recurrences. The ulcer remains unhealed in 6 cases, and in 1 case the patient was not traced.

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Discussion

Dr. Donald W. Smith, Miami: Dr. Bowen has covered well the surgical management of the postphlebitic leg. There are, however, a few points which I should like to emphasize.

The edema and varicosities, and the weeping eczema and ulceration seen in these patients do not usually subside spontaneously, but progress if untreated. They result, of course, from the venous stasis and the tissue anoxia caused by the occluded veins or the recanalized and now valvularly incompetent, previously thrombosed veins. The treatment therefore is based upon these particular pathologic physiologic abnormalities.

The method of approach frequently is a problem. Many of these patients, certainly those hospitalized for treatment at the various public and Veterans Administration hospitals, have already had some form of medical management, and various conservative measures have usually been tried. The question is what to do first, and in what order to proceed with the various measures.

Local medications and pressure dressings alone are frequently inadequate. The medications frequently do more harm than good. The ulcers with active bacterial infection require systemic antibiotic or biochemical therapy. One may get into serious trouble, however, with almost harmless local medications because of decreased resistance of these tissues. It is often difficult to convince the patient of this fact.

Pressure dressings, when used, should be applied with care, reapplied and readjusted frequently. The patient should be instructed in their use to avoid creases and trauma to the skin.

Operations, as previously stated, consist principally of venous ligation, sympathectomy and skin graft. Saphenous vein ligation is limited to those cases with extensive varicose veins. Ligation of the deep venous system is undertaken to prevent backflow of venous blood through the recanalized, previously thrombosed veins which never again develop competent valves necessary to prevent this abnormal mechanism. Since the the profunda femoris is not usually involved with thrombosis, ligation of the deep venous system is limited to the superficial femoral vein. Ligation is never in continuity but with severing of the vein in order to interrupt at least the segmental sympathetic nerves along its course. We have performed a number of popliteal vein ligations and have not found this procedure superior to superficial femoral ligation even though it might have appeared that thrombosis and valvular insufficiency were entirely below the knee.

Lumbar sympathectomy is more valuable than one might think unless one analyzes the rationale. Many postphlebitic legs sweat profusely, thus favoring a fungus infection, which is later complicated by a secondary bacterial infection and progressive ulceration. Interruption of sudorific function by sympathectomy is important in controlling this sequence. Another factor indicating the need for sympathectomy is the intense reflex arterial spasm resulting from painful acute thrombophlebitis. Finally, the postphlebitic edema itself may mechanically occlude many arterioles in the skin. Following lumbar sympathectomy there is therefore better control of fungus infection and improved arterial blood supply to the skin. Sympathectomy and superficial femoral ligation may both be required in the severe postphlebitic syndrome.

There is little indication for sympathetic nerve block even with the long-acting drugs as interruption should be permanent if these patients are to be rehabilitated. Mere healing of an ulcer of the leg in a bed patient is inadequate. Many of these patients will never subscribe o the necessary living restrictions which must be prescribed for all.

Dr. George W. Morse, Pensacola: I think this paper is most timely, and one similar to it should be on every medical program in order to keep the general practitioner, the internist, and the surgeon acutely alert to prevent thrombophlebitis in their patients. In my opinion most of the progress in the treatment of this condition will lie in its prevention. The adequate intake of fluids, early adequate ambulation, prevention of distention, adequate treatment of infections, abstaining from the use of garters, gentle surgery, control of obesity, application of elastic bandages in the aged, improvement when possible in the cardiovascular function, and leg exercises must be insisted upon by every practitioner who treats the acute illnesses, maternity and surgical patients. Particularly in the aged and those with cardiovascular disease should one be most alert to prevent this complicating condition.

If we will accept the fact that the venous circulation is never again as good after a deep vein thrombosis as before regardless of the method used during the acute state, we, as physicians, will more diligently try to prevent an occurrence of this condition.

Once thrombophlebitis has occurred, however, too often patients are not adequately informed of its seriousness and of the work which must be done by the doctor and the patient to ameliorate the complications. I have found few doctors who take the time adequately to prepare the patient for the future. Patients should be advised that trauma, fungus infections, and even a furuncle around the ankle on the affected leg are potentially much more hazardous to their well-being than if they were on the uninvolved extremity. These patients should be cautioned against becoming obese and should refrain from jobs involving long periods of standing.

As Dr. Bowen pointed out, once the chronic daily recurrent edema gains headway, induration with painful ulceration ultimately follows. When this has occurred, one can readily see that there is little uniformity of treatment. Whether one should attack the varicosites of the saphenous system, or ligate the superficial femoral veins, or excise the ulceration and area of induration followed by split thickness graft, or perform a sympathectomy, or just apply elastic bandages becomes a problem of individual judgment and technical ability.

It is my opinion at the present time that the proper surgical procedure, once the induration and ulceration have occurred, should consist of widely excising the ulceration plus all of the indurated area including the underlying fascia down to the bone or muscular tissue. This often will extend from halfway down the lower leg to the foot. Small drill holes are made in the bone, and ligation of all veins feeding the indurated area is carried out, followed by a split thickness skin graft. The patient is carefully observed following the grafting, and lumbar sympathectomy is resorted to if the edema increases or the grafted area begins to ulcerate.

I have not ligated the superficial femoral vein in the chronic thrombophlebitis case as the reports on its use by those employing this procedure have not been enthusiastic. The ligation of this vein does not sound too logical anyway as in those cases in which I have, for acute phlebothrombosis, ligated it, a residual edema has always followed. In those in which anticoagulant therapy was used instead of ligation, there was the same residual edema if normal activity was followed. I can see little reason why one would expect ligation late in the disease to aid materially in cases of this type.

In regard to the saphenous ligation and stripping, I should like to say that one may have incompetency of the saphenous system at any time in the normal or the post-thrombophlebitic leg. If this occurs, high ligation followed by stripping is definitely indicated. I believe, however, that if compensatory varicose veins develop in a leg which has previously had deep vein thrombosis, ligation of them usually will not help the return circulation and frequently will make it worse. The Perthes, Trendelenburg, and comparative tourniquet tests will usually differentiate between the two types.

In New Orleans, Dr. Howard Mahorner is now treating patients with thrombophlebitis with a newer approach and technic which I am sure we all hope will prevent the post-thrombophlebitic syndrome. He incises the superficial femoral vein, removes the clot, and closes the

opening in the vein without ligating it. At the moment, he is reserving this procedure for those cases seen during the first 96 hours after the symptoms of a thrombosis in the major vein of the extremity have occurred. Following the closure of the vein, a polyethylene tube is placed in a superficial vein of the same extremity lower down, and the patient is heparinized. Each hour the nurse is instructed to put a tourniquet around the lower thigh just tight enough to constrict the superficial veins and shunt the heparin into the deep system and heparinize the level at which the vein was opened. This work has not as yet been published, Dr. Mahorner informs me. I am sure we all hope that this method will ultimately prevent the post-thrombophlebitic syndrome.

Treatment of Creeping Eruption

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With the advent of the rainy season, roughly from July through December, physicians of the Southeastern United States will once again be confronted with cases of creeping eruption or larva migrans. Past experience indicates that few physicians are aware of the modern treatment for this interesting skin condition. Indeed, the 1953 volume of Current Therapy describes the archaic and barbaric methods of treatment, passes over "larvicides" rapidly, and concludes: "In general, ideal treatment for this condition is still unknown." It is the purpose of this report to disseminate knowledge of a satisfactory and simple method of treatment which, if not "ideal," is certainly much to be preferred to the older methods still widely employed.

As described in standard texts, the term creeping eruption embraces three distinct skin problems: (1) acarine burrowers (scabies), which are clinically characteristic; (2) cutaneous myiasis (screwworm) due to the larvae of certain flies, which may assume several patterns, but usually is characteristically painful and furuncular; and (3) nematode parasitism, or creeping ancylostomiasis. It is only the last form which is under discussion, and it is this form that is almost invariably referred to by the more common terms larva migrans and creeping eruption. This disease is caused by the filariform larvae of the nematode Ancylostoma braziliense, the natural hosts of which are cats and dogs, and in moist sand or earth mature filariform larvae develop which are capable of penetrating human skin on direct contact. The condition therefore starts in a manner similar to the "ground itch" of human hookworm infestation, but these canine and feline counterparts are unable to reach adulthood in human hosts and confine their wanderings to the surface of the body. Recently reported, however, are cases of disseminated granulomatous lesions in the internal organs of children which are due to this same larva. Early treatment of the cutaneous form therefore becomes all the more important.

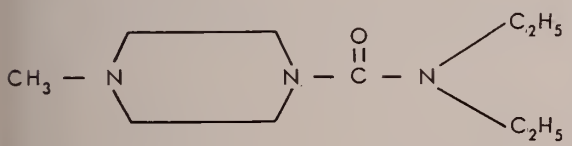
The larvae are microscopic, measuring 0.5 to 0.6 mm., but the tunnels produced by migration are considerably greater in size, usually measuring about 4 to 6 mm. in breadth. The tunnels appear in two or three days after the original red, itchy papule is present, progressing from several millimeters to even centimeters each day. The worms may wander for several weeks, or even months, and the tunnels are solitary or multiple according to the number of larvae present. The lesion is first seen as a reddening of the skin at the leading point, then becomes elevated and perhaps vesiculated; the after-trail heals slowly so that it is usually obvious in which direction the larva is traveling. The tract is tortuous or serpiginous, and readily distinguishable from the straight progression of lymphangitis, which is not infrequently seen in association or as a differential diagnostic lesion.

Pathologically, it has been determined that the larva migrates through the stratum granulosum and the derma. The elevated red streak results from edema, congestion, and infiltration with round cells and eosinophils which respond to the fluid and debris left in the burrow by the advancing larva. The eruption is pruritic, and often leads to secondary infection from scratching. In addition, occasionally there is a generalized urticarial reaction, especially in children. The diagnosis is almost always obvious by inspection, and frequently has already been made by the patient or one of his previously afflicted friends.

Treatment

Treatment in the past has necessarily taken the form of local destruction of the worm, with concomitant destruction of a variable amount of healthy tissue. Freezing with ethyl chloride spray, or carbon dioxide in the solid state, local injections of a multitude of noxious agents, onion poultices, surgical excision of what is hoped to be the tissue containing the larva, and many less orthodox therapeutic measures all have their advocates. As a result, frequently the treatment of the secondary infection and necrosis of skin becomes a problem of greater magnitude than the original infestation, and the eventual outcome, after the larva has succumbed from sheer exhaustion, is a mass of iatrogenic scarring.

My associates and I employ treatment consisting of calculated doses of an oral filaricide, which is safe and inexpensive, and no local measures need be employed. The agent is Hetrazan, a synthetic filaricide first used in 1947 on human cases of Wuchereria bancrofti, Loa loa, and Onchocerca volvulus.



The drug contains no heavy metals, and is marketed in the form of the dihydrogen citrate salt of 1-diethylcarbamyl-4-methylpiperazine. In man, toxicity is negligible in therapeutic doses. It was at first available in 50 mg. tablets, and later as a syrup containing 120 mg. per teaspoonful, which is a more convenient dosage form. The drug is effective against Ascaris, in a recommended dose of 6 to 10 mg. per kilogram of body weight given three times daily. Although it is not effective against adult hookworm, it was found to be effective against the filariform larva. The first report of its use that I know of was by Van de Erve in the Journal of Investigative Dermatology in January 1949. He reported good results in larva migrans with a dosage of 2 mg. per kilogram of body weight three times a day for 10 to 21 days. The drug first came to our attention when an abstract was published in the Navy Medical Corps newssheet in 1950. We have been increasingly enthusiastic since that time, and have arrived at the present dosage schedule through trial and error.

Report of Cases

Case 1. — A 5 year old boy was first seen on July 5, 1950 with pruritic skin eruption on the feet, originally treated as dermatophytosis. On July 7 diagnosis of larva migrans of the dorsum of the right foot was made, and he was given Hetrazan, one tablet (50 mg.) three times a day. His weight was 18 Kg. On July 12 the tunnels were still progressing, and dosage was increased to two tablets (100 mg.) four times a day. On July 17 the disease was completely arrested, and the Hetrazan was discontinued. There was no recurrence on subsequent observation. The drug was well tolerated. The original dose of 2.5 mg. per kilogram of body weight three times a day was insufficient. The subsequent dose of 5 mg. per kilogram four times a day, or 7 mg. per kilogram on a basis of three times a day was sufficient.

Case 2. — A 4 1/2 year old boy, first seen on Aug. 15, 1950 with typical larva migrans on the sole of the left foot, was given Hetrazan, two tablets (100 mg.) three times a day. His weight was 15 Kg. The disease was completely arrested by August 29 and did not recur. The drug was well tolerated, and the dose of 7 mg. per kilogram of body weight was sufficient.

Case 3. — A 30 year old tile setter first came under my observation on Oct. 27, 1951 after six weeks of unsuccessful therapy for larva migrans contracted while working on the ground without gloves. He had been treated with local ointments, heavy ethyl chloride spraying, and penicillin injections. There was an active, progressing tunnel under the palmar skin of the right hand with much secondary infection and regional lymphadenitis and lymphangitis. He was given a single injection of penicillin-streptomycin combination intramuscularly, and Hetrazan, two tablets (100 mg.) three times a day, was prescribed. His weight was 64 Kg. Complete arrest and healing of the original lesions were noted on November 6, and there was no recurrence on subsequent visits. The drug was well tolerated. The dose of 2 mg. per kilogram of body weight on a basis of three times a day was sufficient in this case.

Case 4. — A 9 year old girl with larva migrans of the left arm and abdominal wall, was first examined on July 1, 1952. Extensive tunnels measuring several inches in length had been progressing for several days, but the patient finally consulted me because of generalized urticaria with the eyes swollen almost shut. The urticaria was controlled with oral antihistaminic therapy and local antihistaminic lotion. She was given Hetrazan, one tablet (50 mg.) three times a day with meals and 2 tablets (100 mg.) at bedtime. Her weight was 28 Kg. On July 10 the disease was arrested, and the original lesions were healed; there was no recurrence on later observation. The drug was well tolerated. The dose of 3 mg. per kilogram of body weight on a basis of three times a day was sufficient in this case.

Case 5. — A 43 year old man with a typical burrow of larva migrans on the dorsum of the left foot, about 5 inches in length and of one week's duration, consulted me on July 25, 1952. He was given Hetrazan, three tablets (150 mg.) four times a day. His weight was 77 Kg. The original tract was healed by August 6, but a new tract had appeared from the original site, extending for several inches in a different direction. The dose was therefore increased to 15 tablets (750 mg.) three times a day for five days. On August 12 the disease was completely arrested, and there was no recurrence. The drug was well tolerated. The original dose of 3 mg. per kilogram of body weight on a basis of three times a day was insufficient; the second dosage of 10 mg. per kilogram proved to be most effective.

Case 6.—A 36 year old housewife, first examined on Oct. 28, 1952, had numerous short but typical tracts of larva migrans about the first two toes of the right foot and one tract on the dorsum of the left foot. She was given 4 teaspoons of Hetrazan syrup (480 mg.) three times a day. Her weight was 80 Kg. On November 8

the right foot was cleared, and the original tract on the dorsum of the left foot was healed, but there was a new active burrow on the dorsum of the left little toe which had turned back on approaching the foot and continued out to the base of the nail as though attempting to stay in an area of relatively poor blood supply. The Hetrazan was increased to 6 teaspoons of syrup (720 mg.) three times a day. The patient experienced nausea of considerable degree after each dose, but this had been minimized by taking the drug immediately after eating and did not increase with the increased dosage. The disease was completely arrested on November 15. The original dose of 6 mg. per kilogram of body weight on a basis of three times a day was apparently not sufficient; the subsequent dose, however, of 9 mg. per kilogram three times a day was sufficient.

Case 7. — A 53 year old mail carrier first consulted me on Dec. 5, 1952 and gave the following history: On October 16 he sat under his house for seven hours engaged in an amateur plumbing job. That evening there developed intense itching "all the way across the buttocks." He had experienced no previous itching, skin trouble, or pruritus ani. Three days later he consulted Dr. A., whose diagnosis was "fungus" and who prescribed liquid fungicide. The condition grew worse. On October 22 he consulted Dr. B. His diagnosis was larva migrans, and he prescribed ethyl chloride spray. Three days later he consulted Dr. C., whose diagnosis was larva migrans. He was hospitalized and treated for four days with Vicks Vapo Rub spread around the buttocks with constant heat from an electric heating pad applied to the area. "By this time I thought my buttocks would drop off," he related. He was referred from the hospital to a dermatologist in another community.

On October 29 the patient consulted Dr. D., the dermatologist. His diagnosis was larva migrans, and he prescribed dry ice locally. Dr. D. sent him back to Dr. C. with the suggestion to continue the dry ice. At this stage there were bad burns all over the buttocks, the tracts were still extending, and itching was almost intolerable. He did not return to Dr. C. From October 30 to December 5 he treated himself with various preparations suggested by friends and local pharmacists. These included Tetterine, a 10 per cent solution of salicylic acid in collodion, Hermesol, Pyronil, a sulfur and olive oil preparation, various analgesics and antipruritics. There was no improvement. He had now been unable to work for seven weeks.

On my first examination on December 5, there was extensive creeping eruption with innumerable serpiginous tracts covering both buttocks. Lesions were secondarily infected and excoriated with little or no normal skin in the entire area. Within the cleft between the buttocks the appearance was that of objective pruritus ani, and the patient was warned that this might be a problem after the lava migrans was controlled. Hetrazan, 5 teaspoons of syrup (600 mg.) three times a day, and oral antihistaminic therapy for the itching were prescribed. His weight was 70 Kg. From that date, there was no further extension of any tract, and by December 15 all burrows were healed. Subsequently, the patient was treated for the pruritus. Several Scotch tape smears were negative for pinworms. Success was not obtained until a lengthy course of superficial roentgen ray therapy was completed on March 3, 1953. He had returned to work in December, and there was no recurrence of the larva migrans. He experienced nausea after each dose of Hetrazan, but was able to retain the drug. The dose of 8 mg. per kilogram of body weight on a basis of three times a day for nine days was sufficient.

Four other patients received Hetrazan therapy for larva migrans during the period covered by this report, but they were of the transient population and were not followed sufficiently for the cases to be reported. One of the four, an adult, experienced nausea after each dose. So far as is known the result in each case was satisfactory.

Discussion

Hetrazan appears to be a safe, simple, inexpensive and most effective therapeutic agent for larva migrans. In all cases in which we have used this drug the response, usually dramatic, eventually has been successful when adequate dosage was used. There seem to be no toxic reactions when this drug is used for this purpose. Some rather violent reactions have been reported following the use of this agent on human filarial parasitism, and a local veterinarian reports some fatal reactions after using this agent on dogs infested with heartworms, which are apparently mosquito-borne filarial worms. It is probable that these reactions are related to anaphylactic response to released filarial protein when the worms are killed, and not directly due to the filaricide itself. This, to our knowledge, is not a problem in the treatment of larva migrans, and neither have we had any untoward reaction in using Hetrazan for Ascaris in humans. We find it most effective for this purpose also, and at present it is the agent of choice in our clinic.

Side reactions seem to be of no great consequence. Three of the patients experienced nausea with each dose, but were able to complete the course of therapy. The nausea was reduced to a minimum by taking the drug immediately after meals. The dose which is effective seems to vary in individuals regardless of the age of the patient or the severity or extent of the infestation. At present however, we believe that a fairly large dose for a relatively short time is most satisfactory. The occasional nausea encountered does not seem to be related quantitatively to the size of the dose. The originally recommended dose of 2 mg. per kilogram of body weight on a basis of three times a day we find is too small in most cases. We prefer to give 9 or 10 mg. per kilogram per dose, administered three times a day immediately after meals, for a period of five or six days. This is most conveniently given in the form of the syrup, which contains 120 mg. per teaspoonful, and a 1 pint bottle, costing the patient about $7 or $8, will be more than enough for all but the heaviest patient. It would be better if the concentration of the drug could be increased, so that 1 or 2 teaspoons would constitute an adequate dose.

In addition, appropriate antibiotic therapy is frequently necessary for secondary infection, and for itching, whether local or generalized, oral antihistaminics seem to be effective. There seems to be little indication for local measures, and certainly none for destructive agents. From the standpoint of prophylaxis, it is well to advise all patients living in contaminated areas to venture forth from the house only if properly shod, especially during the rainy season. People whose occupation or hobby requires working with the hands in wet soil, especially around houses or lawns, should do so only while wearing proper gloves.

Summary

Creeping eruption, in the form of larva migrans or creeping ancylostomiasis, is a form of parasitic infestation of the skin caused by the filariform larva of the dog and cat hookworm, A. braziliense. This larva can penetrate the human skin on direct contact with contaminated soil and produce a most disturbing skin lesion characterized by serpiginous burrows and itching.

The worm, in the deep layers of the skin, has previously been extremely difficult to eradicate, and therapeutic attempts have produced scarring and disability in excess of that caused by the worm. A new filaricide compound called Hetrazan has proved to be effective, as well as safe and economical, in rapidly controlling this parasitic infestation. The recommended dose is 9 to 10 mg. per kilogram of body weight, administered three times a day after meals, for a period of five or six days.

Seven illustrative cases are presented.

Addendum

Nine patients have been treated since this paper was submitted, with uniformly successful results. Of this number, 3 experienced severe nausea.

Sarasota Medical Clinic,
Florasota Gardens.

Medicine at the Crossroads: 1933 -- 1953

Louis M. Orr, M.D.
ORLANDO
President-Elect, Conference of Presidents

It has been pointed out many times by wise men that we can learn much from a thoughtful study of the past — and that by doing so we can gain a better perspective on the present and the future.

One of the wise men who offered such advice to the medical profession was the late Dr. Harvey Cushing of Boston, an eminent and honored figure in the history of American medicine. Twenty years ago, almost to the day, Dr. Cushing delivered a memorable address in which he said:

"A recent leader of public opinion openly states that most of those at present dealing with the sick — meaning more specifically the doctor — have their faces turned toward the past. If history but repeats itself, where else but the past can we learn anything? We certainly can draw little comfort and few admirable lessons from the late present."

Here, today, acting upon Dr. Cushing's timely and timeless advice I propose to look at the past. More specifically, I am turning back to the very address from which I have quoted — Dr. Cushing's presidential address before the Congress of Physicians and Surgeons in Washington, D. C., on May 9, 1933.

In that speech twenty years ago he said many things which bear repetition today, but I shall select just a few of his most pertinent remarks. Some of the remarks illustrate that the problems, questions and criticisms of 1933 have their counterparts in 1953. Other remarks serve as points of reference which show that the past two decades have brought not only outstanding scientific advances, but also great progress in the human relations aspects of medicine. All of Dr. Cushing's remarks, in my opinion, should help to stabilize our philosophy, our faith, our tolerance — and our blood pressure.

Read before the Conference of Presidents and Other Officers of State Medical Associations, Ninth Annual Meeting, New York, May 31, 1953.

Dr. Cushing, for example, was concerned twenty years ago about the Utopian medical proposals of the social reformers and the early rumblings of the socialistic threat. Near the opening of his address he mentioned "The present crux in which the medical profession finds itself, overmanned, over-specialized, like other necessities of life poorly distributed, an expensive luxury for those of modest means and the subject of investigation by a commission which threatens us with socialization unless we promptly do something to alter our spots, to cast off our long-conditioned reflexes, and put ourselves on a modern chain-store business basis."

In view of the developments of the past few years, most of that sounds quite familiar. Continuing on the same subject, Dr. Cushing said in 1933:

"Nor would this seem to be the time to fly to evils we know not of, but rather to stick firmly to what has proved in the long run the great stabilizer — every honest man with faith, hope and a stout heart going about his own business, with swift punishment for dishonesty and crime."

Then, after commenting that social reformers sometimes lose their heads, and pointing out the folly of sitting down with pencil and paper to remake the social world, Dr. Cushing expressed this thought:

"Heaven knows there are plenty of things the commoner, including most doctors, would like to see corrected and the sooner the better . . . and the doctor wonders why, just at this time, when in spite of widespread distress and anxiety the health of the people as a whole is better than ever, he should be particularly singled out and told if he doesn't distribute himself more evenly, stop specializing and charge less, he'll be coerced into doing so. He thinks this highly peculiar, for hasn't he always striven with ever-increasing success to eliminate one after another the diseases whose particular care provides his bread and butter? And has he not shared with the priest, from the beginning of the record, in giving a large part of his time to the indigent poor in whom business, finance and the law may be theoretically interested without showing it in so direct and practical a way?"

Twenty years later we in medicine still express that same wonder, still ask those same questions — but we also are doing a number of things to explain the wonder and answer the questions. Since Dr. Cushing spoke in 1933, medicine's scientific and technical advances have followed one upon another in almost breath-taking fashion, the health of the American people has continued to improve at an even faster rate than before, and we have witnessed the phenomenal growth and development of voluntary health insurance. Yet, we still have the same basic problems, criticisms and threats which confronted us then. At the moment, it is true, the criticisms and threats are less intense and less menacing than they were four years ago. Nevertheless, we should bear in mind that Dingells and Murrays still roam the halls of Congress, that politically-inspired commissions continue the effort to propagandize their proposals and that a wide variety of socio-medical planners still lurk behind the scenes, waiting for another try.

While there are similarities and counterparts in the present medical situation, as compared with that of 1933, there also are one or two interesting differences which are revealed by Dr. Cushing's quoted comments.

You may have noted that he referred to the medical profession as overmanned. In other words, twenty years ago — when this country was just beginning to emerge from the great depression — many people in and out of the profession complained that there were too many doctors and too many empty hospital beds. Now, despite the fact that for many years the number of physicians has been increasing at a faster rate than the general population, we hear a continual hue and cry over an alleged shortage of doctors. It is just quite possible, of course, that the propaganda requirements of the social planners — not to mention the natural workings of the law of supply and demand — have something to do with this peculiar reversal in the list of our shortcomings.

Another noteworthy difference lies in the fact that Dr. Cushing, speaking in 1933, could say little or nothing about voluntary health insurance. Twenty years ago hospital insurance plans, conceived during the depression, were in their early, uncertain infancy, and surgical and medical plans were not to appear on the economic scene for another six years. Today, with the active support and encouragement of the medical profession, the nation's hundreds of voluntary plans protect more than 90 million Americans against hospital, surgical or medical expenses — and they are growing and improving every day. The expedient social planners, of course, now dismiss that frustrating

fact with the insistent claim that the voluntary plans are still woefully inadequate.

At this point I should like to emphasize that the threat of socialization still exists in latent form. In 1933, when Dr. Cushing perceived the danger, and for fifteen years thereafter, most of us in medicine did not listen seriously to the many warnings which were sounded. During those fifteen years the social planners in and out of government carried on an expanding, intensified program of propaganda and legislative proposals, but we in medicine did nothing positive or effective to provide the necessary antidote.

As a result, by the end of 1948 the danger had become so imminent that we were forced to divert a tremendous amount of time, energy and money to a special campaign against national compulsory health insurance. And while that effort was successful in warding off the immediate threat, and in helping to accelerate the growth of voluntary health insurance, it by no means solved all problems or dispelled all dangers. Today, those who are intent upon socializing medicine have simply made the expedient switch from the tactics of frontal assault to the more subtle methods of infiltration and flank attack.

This span of events from 1933 to 1953, in my opinion, provides a clear lesson for all of us in medicine. In short, we must never again disregard sound warnings from responsible sources; we must never again lose our alertness. Our alertness must be positive rather than defensive so that the social reformers will be deprived of all possible sources of ammunition. We must continue and accelerate the expansion of the medical profession's many constructive programs now under way to make good medical care available to all the American people.

It is interesting to note that when we finally did undertake a vigorous counterattack against the threat of government control, our campaign included a number of basic elements and ideas which Dr. Cushing touched upon in his address of twenty years ago — the chain-store nature of socialized medicine, the value of individual initiative, the nation's health progress, the physician's service to the indigent, the doctor-patient relationship, the role of the family physician and the cost burden of government medicine.

On the latter point, for example, Dr. Cushing commented in 1933 that the chief burden of compulsory health insurance "would fall as usual on the average provident man of good habits." And along the same line he also quoted from the famous "forgotten man" address by William Graham Sumner, who made this still-timely analysis of social reformers:

"They are always under the dominion of the superstition of government, and forgetting that a government produces nothing at all, they leave out of sight the first fact to be remembered in all social discussion — that the state cannot get a cent from any man without taking it from some other man, and this latter must be a man who has produced and saved it."

Some of the other ideas touched upon by Dr. Cushing are embodied in the various constructive programs which I mentioned just a moment ago. In view of the thoughts which he expressed twenty years ago, I believe that Dr. Cushing would be pleased and heartened by the definite progress which is now being made in promoting closer relations and better understanding between physicians and patients. By the same token, I believe that he would find great comfort in some of the current trends in medical practice and medical education.

It is vitally important today, in my opinion, for us in medicine to strive within our own ranks for a still greater recognition of the basic values which Dr. Cushing emphasized. It is essential for us to work even harder on the development and application of those basic ideas in positive, practical medical programs — programs aimed at making adequate medical care readily available to all who need it and want it. Only by such striving and work can we prove conclusively that we are truly progressive, while at the same time we fight to preserve the best traditions and principles of medical practice. The objective, in other words, is to find the best ways of fulfilling our professional and humanitarian ideals in the modern atmosphere of medical economics.

With that in mind, what are some of the basic values and ideas which Dr. Cushing stressed in 1933, and which are pertinent to the problems and programs of 1953?

Discussing the physician-patient relationship, for example, Dr. Cushing pointed out that the doctor is not at his best when dealing with reformers, malingerers and chiselers of various types. Then he went on to say:

"He (the doctor) feels far more at home with the ordinary, self-respecting people of modest means who do not expect, on this earth, to find green pastures provided for them with ten cent cigars, a two-car garage, and a fish fry in every

dinner pail. They frankly say just what their circumstances are and what they can pay and when. For them, too, he can do no more than his best and only wishes it could be better, and cuts their bill in half or cancels it altogether."

At today's prices, of course, if we were to bring the quote up to date we would have to raise the price of the cigar to thirty-five cents, add another car space to the garage, put blue-ribbon steak in the dinner pail — and we probably should throw in a guaranteed life income for good measure.

But to return to 1933 for a moment, Dr. Cushing pointed out the unfortunate fact that many people, especially in the cities, neglect to make a family friend, confidant and adviser of any one physician. When they move from town to city, or from one neighborhood to another, they far too often fail to provide themselves with the services of a family doctor. Then, when they are in need of proper medical care, or when an emergency arises, they are subject to all kinds of questionable suggestions from neighbors, friends and relatives. "What's to be' done," Dr. Cushing asked, "to save them from themselves and keep them from 'shopping around' as it is called?"

I think that Dr. Cushing would be heartened by what the medical profession is doing today, not only to provide an answer to that specific question but also to revive, improve and strengthen the doctor-patient relationship in all its aspects. The state and county medical societies, with the active encouragement and help of the American Medical Association, have made notable progress in this field during the last five years.

For example, approximately 650 medical societies now are operating twenty-four hour emergency call systems, to help people obtain medical services without delay. There are approximately 500 state and county grievance committees to settle misunderstandings between patients and physicians over fees, professional services, medical ethics and other problems. All members of the profession are being urged to discuss the costs of their services openly and frankly with patients, to avoid misunderstandings, and increasing thousands of physicians are displaying the American Medical Association plaque which invites patients to ask questions about fees and services. More and more medical societies are initiating programs designed to guarantee medical care to anyone who needs it, regardless of ability to pay, and the American Medical Association House of Delegates has taken official action urging all medical societies to adopt such programs.

On national, state and local levels, medicine is increasing its efforts to convince the people that it is wise to have a personal physician. At the same time, medical societies are pushing ahead with a variety of programs aimed at improving the personal public relations of individual physicians and the community relations of the professional group as a whole.

These and similar activities — moving forward on practical public relations ground which was largely unexplored twenty years ago — are designed to restore the human, friendly values which once were so predominant in the doctor-patient relationship. They are gaining momentum throughout the country, and it is our responsibility to see that they develop with maximum speed and efficiency.

Closely related to the over-all problems of the doctor-patient relationship is the role of the general practitioner or family physician — and the ever present issue of specialization versus general medicine. That issue was a controversial one when Dr. Cushing spoke twenty years ago, and it still is with us — but here too we can see heartening developments. But first let's see what Dr. Cushing had to say on this subject in 1933, and now I have several different quotes:

"He (the general practitioner) has supposedly gone out of business, pinched on one side by the public health officer and periodic life-extension examiners, and on the other side by what are called the scientific doctors, including ourselves, the specialists in our respective hospitals. . . .

"Indeed, it is authoritatively said that the automobile and the associated highways together with the present 'set-up' of society have driven out the unmethodical, silk-hatted, bewhiskered, lovable and friendly general practitioner. . . .

"But even though his whiskers have gone with his tall hat, if he ever had one, and he comes in a motor car instead of behind a horse, and nervously smokes too many cigarettes, the general practitioner or family doctor is still with us and plays the same important role he always has.

"For nine tenths of what he is called upon to do 'the operating table and the microscope and the roentgen ray and the trained nurse and the mechanotherapeutist' are wholly unnecessary; and when they are needed he usually knows where to get at them. . . .

"Such are the men who represent the backbone of our profession and for each of them there are countless devoted patients and for each patient whole families whose voice in our discussions has not as yet been heard. . . .

"It is to the self-sacrificing spirit of the sagacious practicing doctor, not to the likes of us in this, that or the other line of special work, or the medical scientists, or the public health official that from the earliest times tribute has been paid. . . .

"Three fifths of the practice of medicine depends on common sense, a knowledge of people and of human reactions. . . .

"There has been much idle talk, too, regarding scientific medicine and the modern scientific doctor who with his ingenious appliances and mathematical exactitude has come to supplant the old-fashioned 'practical' doctor. . . .

"We have instruments of precision in increasing numbers with which we and our hospital assistants at untold expense make tests and take observations, the vast majority of which are but supplementary to, and as nothing compared with, the careful study of the patient by a keen observer using his eyes and ears and fingers and a few simple aids. The practice of medicine is an art and can never approach being a science even though it may adopt and use for its purposes certain instruments originally designed in the process of scientific research."

In what I have quoted, and in many other parts of his 1933 address, Dr. Cushing touched upon a number of points which remain as familiar issues today — specialization versus general practice, scientific medicine or the human touch, the respective roles of the public health officer and the private physician, the proper emphasis on prevention, which Dr. Cushing described as a greatly over-worked catchword, and similar questions.

Today, twenty years later, the general practitioner still has not been displaced by the specialist, the public health officer, the research scientist or the expert on disease prevention. The family doctor still is going strong; in fact, he is going stronger. And the voice of his many loyal patients and friends finally has been heard, as witness the great public support for our campaign against socialized medicine.

Despite the still-persistent cry against overspecialization, the facts show that there actually has been a definite trend in the opposite direction since the end of World War II. Along with the growing emphasis on treatment of the whole patient — physical, mental and emotional — there has been a resurgence of interest in general practice. This is increasingly evident in medical schools, hospitals, professional organizations and throughout the entire fabric of our medical care system.

For example, recent surveys show that during the last four or five years an increasing percentage of medical students plan for a career in general practice, and a decreasing percentage intend to specialize. A number of medical schools are experimenting with curriculum changes placing greater emphasis on general practice, and designed to give correlated training in the basic sciences, the principles of medicine and the clinical care of patients. More and more hospitals, in their intern and resident training programs, are making provision for the young doctor who plans to be a general practitioner. The American Medical Association, at its Clinical Session held each year in December, designs the program especially for the benefit of the family doctor. Another organization, formed just five or six years ago, is the American Academy of General Practice, devoted to the problems and interests of the general practitioner. In the doctor placement programs which now are in operation in at least thirty-two states, major emphasis is on the task of obtaining well-rounded family doctors for the smaller communities. The same is true of the medical scholarship programs which have been set up by state medical societies.

I believe that Dr. Cushing, in view of the ideas he expressed twenty years ago, would look approvingly on all these current trends in medical practice and medical education.

Finally, as I come to the end of this address, let me turn once more to Dr. Cushing for some timely advice and philosophy:

"What this puzzled world needs perhaps is more study of the past, fewer commissions and surveys of the present, and a greater number of philosophically minded, self-supporting and law-abiding persons who can see all around their particular problem and independently devote themselves to it as do most doctors. . . .

"And should the doctor, in moments of discouragement about the shortcomings of his own tribe, now so thoroughly ventilated as to make those he is most anxious to help have misgivings about him, need like other people a timely word of comfort, he can remember that, whatever the

doctor of the future may come to be, it has been said not long ago of the doctor of his particular time — and with some small measure of truth by one who had good reason to know him well — that:

" 'He is the flower (such as it is) of our civilization; and when that stage of man is done with, and only remembered to be marveled at in history, he will be thought to have shared as little as any in the defects of the period, and most notably exhibited the virtues of the race. Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Heraclean cheerfulness and courage. So it is that he brings air and cheer into the sickroom, and often enough, though not so often as he wishes, brings healing'."

From Dr. Cushing, and from all of the best in the past, we can learn this lesson, if we do not already know it: medicine always has had its problems, obstacles and criticisms, and it probably always will. We must face our problems, whatever they may be, with a philosophy based on the ancient virtues of faith, hope and charity and on the highest traditions and ethics of medicine. By so doing, we shall not only gain mental and moral comfort, but we shall also find ourselves closer to the practical solutions of the problems.

1300 Kuhl Avenue.

ABSTRACTS OF MEDICAL ARTICLES

The Comparative Efficacy of Routine Procedures for the Bacteriological Diagnosis of Tuberculosis in a Public Health Laboratory. By Mildred B. Jefferies and Albert V. Hardy. Pub. Health Lab. 10:130-136 (Nov.) 1952.

The reliability of procedures used in the diagnosis of tuberculosis is evaluated in the Jacksonville laboratory of the Florida State Board of Health on the basis of comparative efficacy of technics. During four years 71,852 specimens were examined by concentration smear and by culture.

The percentage of specimens found positive by smear during this period was relatively constant with a slow decline from 13.1 per cent in 1948 to 10.0 per cent in 1952. The culture findings varied widely with the progressive increase in the proportion of positive cultures rising from 9.6 per cent in 1948 to 18.1 per cent in 1952. In recent months the cultures frequently have revealed twice as many positives as the microscopic smear examinations.

A major unsolved problem in the bacteriologic diagnosis of tuberculosis is assuring viability of organisms on arrival in the laboratory, a troublesome problem in Southern states during hot summer months.

Brucellosis. The Work of M. Ruiz Castaneda, M.D. and the Medical Research Institute, Mexico City, D. F. By Lydia Allen DeVilbiss, M.D. J. Am. M. Women's A. 7:412-414 (Nov.) 1952.

As the title indicates, the author reviews the work of Dr. M. Ruiz Castaneda, distinguished Mexican physician and scientist, and the National Medical Research Institute of Mexico City on brucellosis. Original work on this disease at the institute includes the spot test, the surface fixation test, the simplified method of blood culture, and the vaccine known as MBP. In production of MBP the three species, Brucella melitensis, Br. abortus and Br. suis, are ground together and fractionized.

In Mexico, where brucellosis is prevalent, the chief type of organism is Br. melitensis. Of more than 6,000 cases of brucellosis treated with MBP at the institute, in not more than 30 per cent have the patients returned for retreatment. Antibiotics used in treatment of acute and subacute brucellosis have given excellent results. For active chronic brucellosis, MBP is the most effective treatment. A case is reported which illustrates the value of MBP vaccine.

Agranulocytosis Following Phenylbutazone Therapy, Report of a Case. By S. Charles Werblow, M.D., and Jacob Neber, M.D. J. A. M. A. 151:1286-1289 (April 11) 1953.

A case is reported in which agranulocytosis developed following treatment with the new antirheumatic drug phenylbutazone (Butazolidin). The patient showed high fever, sore throat, great toxic prostration, morbilliform rash, and severe granulocytopenia and leukopenia together with a maturation arrest of granulopoiesis in the marrow. Withdrawal of phenylbutazone and treatment with antibiotics, small fresh whole blood transfusions, and corticotropin (ACTH) produced dramatic recovery. The importance of close hematologic observation of all patients receiving phenylbutazone therapy is stressed.

The Early Recognition of Bronchiogenic Carcinoma. By Jim S. Jewett, M.D. Dis. of Chest 22:699-708 (Dec.) 1952

In the opinion of the author there are significant early symptoms and roentgen abnormalities in a high percentage of cases of bronchiogenic carcinoma which will suggest a presumptive diagnosis and lead to specific diagnostic methods. In focusing attention on this aspect of cancer detection, he reports a series of 150 cases of histologically proved bronchiogenic carcinoma in which an average of 10.5 months elapsed between the onset of symptoms and the establishment of a correct diagnosis. Delay attributable to the patient averaged 4.1 months and to the physician 6.4 months. In the latter instance it was ascribed to unawareness of possible significance of minor respiratory symptoms, failure to obtain a chest roentgenogram early in the course of the disease, and overlooking or misinterpreting significant departures from normal.

Dr. Jewett correlates the early clinical and radiographic features of bronchiogenic carcinoma with its site of origin within the bronchial tree, namely, those arising (1) in the main stem or lobar bronchi (58 per cent); (2) in the segmental bronchi (19 per cent); and (3) in the periphery of the bronchial tree (23 per cent). A number of illustrative cases are briefly summarized.

This correlation, he believes, should promote better understanding of the protean manifestations of this form of cancer. The survey chest roentgenogram, he observes, promises to be one of the most valuable tools available today for the early detection of primary pulmonary malignant disease.

Water-Soluble Contrast Medium for Bronchography. By M. Eugene Flipse, M.D., Gustav A. Hedberg, M.D., and Victor R. Krueger, M.D. A. M. A. Arch. Otolaryng. 57:-188-205 (Feb.) 1953.

The characteristics of water-soluble mediums, including their composition and physical properties, removal from the bronchopulmonary system and effect on the body, are discussed. Their use in bronchography is evaluated in the light of personal experience and an extensive review of the literature.

The authors present their experiences with a water-soluble medium known as "xumbradil viscous B," used for the diagnosis and localization of bronchopulmonary disease that could not be adequately delineated by more routine methods of study. They report that their results in 58 cases with 79 bronchographies, including 38 in which tuberculosis was present, were in accord with the nearly universally favorable experience of others with this and the other iodopyracet-carboxymethylcellulose mediums.

The definite superiority of solutions of iodopyracet and sodium carboxymethylcellulose as contrast mediums for bronchography has been proved, the authors observe, by a rapidly increasing number of experimental and clinical studies. Since they are stable and water-soluble and are completely and rapidly eliminated from the lungs, they appear to possess none of the objectionable features of the iodized oil mediums. They seem to be free of all systemic toxicity and of other than transient local irritative qualities, even with repeated use in the same person. The few complications noted during their use apparently are not due to the mediums themselves but are complications inherent in bronchography. Modifications in the technic of bronchography, it is concluded, have largely eliminated the minor objections to these mediums.

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From Our President

Our Obligation to the Medical Schools of America

During the year 1952 over 500 contributions were made by Florida physicians to the American Medical Education Foundation, or directly to medical schools, as a part of the response by physicians for support of, and aid to, medical schools of this country. The decreasing income from endowments, the decreasing number of large endowment gifts, and the increasing expense of operation have posed a definite and pressing problem for all medical educators. It has become necessary to appeal directly to physicians, and to all other interested persons, for increasing gifts in larger amounts, to make up the deficits incurred under present income and endowments.

The response of physicians, and of industries and industrialists, has been most gratifying, but the scale of giving must be increased and more persons reached in this appeal for help. We want to avoid governmental subsidies for medical as well as other types of education. If we are to do so, there is only one answer, more money from larger numbers of interested persons.

We fully realize that had it not been for endowment and other income, aside from and in addition to fees paid by students in medical schools, we would not have been able to secure a medical education, unless we were in excellent financial condition. We paid only a fraction of the total cost of our education.

Now we have an opportunity, by generously giving some of our profits from medical practice, to make possible the education of future physicians, who will in due course take our places in the practice of medicine — education, moreover, under a system of medicine which has resulted in the highest level of health in our history. Token contributions are, of course, welcomed, but we should earnestly strive, at all levels of medical organization, to stimulate our individual members to larger and more consistent giving to medical education. Let us share with the coming generation of physicians some of the fruits of our practice, under the Free Enterprise system, which system we are so earnestly striving to uphold and perpetuate.

Send your contribution for 1953, if you have not already done so, to the American Medical Education Foundation, or to the medical school of your choice, today.

Frederick K. Herpel

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Clinical Center a National Health Symbol

Early in July, impressive ceremonies marked the dedication of the Clinical Center of the National Institutes of Health, located in a wooded section of Bethesda, Md. Far more impressive, however, to the members of the Congress, government officials and representatives of the medical and allied professions in attendance was the red brick, 14 story, 500 bed research center itself, unique in hospital annals. This $64 million structure is a worthy symbol of government in medicine at its best.

In dedicating the building, the head of the Department of Health, Education, and Welfare said of the Center: "It is new evidence that the American government continues to be responsive to the people and to the needs of the people. I proudly dedicate this Center to medical research as a symbol of our national concern for the health of our people, for their right to personal happiness unhampered by crippling illness." Secretary Hobby added that the medical scientists at the Center are dedicated to the "endless struggle against human suffering."

Dr. William H. Sebrell, Jr., Director of the National Institutes of Health which will operate the Center, summed up the Center's purpose by saying that medical care is incident to study with interest centering not in rare, exotic diseases, but those which harm and prove fatal to the most Americans. With the Center's 90 physicians, however, research projects never supercede the patient's welfare, and each patient is free to leave if he decides not to continue with the testing and research program to which he agrees on admission.

Plans call for the use of consultants from Washington, Baltimore and other nearby medical centers. While there will be no medical student, nurse, or intern training programs, residencies in medical research are planned with credit given toward boards. The Center will get all of its patients through physician referrals.

The 250 semiprivate, air-conditioned, attractively appointed rooms may not be occupied to capacity for a year or two. At week's end after a Maryland farmer had checked in as "Patient 00-00-01," 22 patients, aged 14 to 71, had been admitted. Six came for cancer studies and 2 for studies of blood distribution; 8 suffered from disease of the heart and arteries, 2 from diabetes, and 4 from arthritis.

For the care of its patients and to man its 1,100 laboratory spaces, the Center eventually will have 100 or more physicians and hundreds of other scientists in a total staff of 3,000. This institution set up by the Congress expressly to facilitate research on diseases is expected to produce no quick miracles. In the uphill fight against the common chronic diseases, however, it provides the long-needed opportunity for unlimited research time at the patient's bedside.

The Philosophy of Public Relations

What do Floridians think about the Florida Medical Association? Do they think well of us? Do they think ill of us? Or do they think nothing at all of us because they know nothing of our organization?

The answers to these questions add up to a good definition of our public relations. Certainly, the citizens of Florida, from whose number we draw our clientele, know more of us as physicians and as citizens than they did not long since. Furthermore, the experiences of recent years have prodded us into full realization that all of our policies and all of our projects must be charted and executed in the light of their effect on the public as well as on the members of the Association. Deliberately, we chose a profession which makes of us servants of the public. In any other role we are out of character.

The basic philosophy of sound public relations is obviously right action. To succeed, the Association must make its decisions in the public interest. No matter how elaborate and how far reaching the public relations' program, its success is vested in public opinion. The road back to the public veneration enjoyed by the universally revered and beloved family doctor of yesteryear lies in rendering the best possible service of which we are capable, not alone in the practice of medicine but also in community leadership.

Even this high goal, however, is not enough. Good performance must be known to be appreciated. We must tell effectively the story of our system of medical care and keep the public constantly aware of it.

In our Bureau of Public Relations we have a staff agency of which we may well be proud. It coordinates our public relations activities and focuses attention on our public relations goals. Its able representatives stand ready at all times to lend a helping hand. But a strong, comprehensive program delegated to efficient lay personnel is likewise not enough.

Fundamentally, right action, a sound program, good performance, all are best interpreted to the public by the component county medical societies. The medical society which is an active public service organization properly can take credit for good performance. It also can be remarkably successful in elevating the prestige of the whole local medical profession.

It is both seemly and important as this eightieth year of the Association's existence progresses to urge upon every component society a positive public service program. Establish and maintain public relations about which you are glad to keep the public informed and about which your community is pleased to learn. Be mindful, however, that in developing such a program the key to success is the knowledge that to win and retain public esteem we must deserve it.

Dr. Chester S. Keefer Becomes Special Assistant to Mrs. Hobby

President Eisenhower's recent announcement of the appointment of Dr. Chester Scott Keefer to the important post of Special Assistant for Health and Medical Affairs to the Secretary of Health, Education, and Welfare occasioned much favorable comment in medical circles. The eminent Boston physician was sworn in on August 12 in ceremonies attended by leading officials of the department.

In order to serve the government and the nation in this capacity, Dr. Keefer has taken temporary leave of absence as physician-in-chief at the Massachusetts Memorial Hospital, a position he has held since 1940, and as Wade professor of medicine at Boston University School of Medicine. Dr. Keefer plans to devote as much time to the post as it requires, and when the work is well under way, he expects to divide his time between Washington and Boston. His outstanding organizing ability is well known.

The new Special Assistant received his medical degree from the Johns Hopkins University School of Medicine in 1922. He has enjoyed a brilliant career in teaching and is an expert on antibiotics, having supervised penicillin and streptomycin distribution for the United States and her allies in World War II. He also was chairman of the National Research Council's committee on chemotherapeutics which advised on civil defense medical stockpiling. A fellow of the American College of Physicians, Dr. Keefer is also a member of the American Society of Clinical Investigation and has served on the Council on Pharmacy and Chemistry of the American Medical Association.

Under terms of Reorganization Plan No. 1 creating the department, the Special Assistant is charged with reviewing and advising the Secretary on all health and medical programs of the department as well as on health and medical legislation. Secretary Hobby is to be congratulated on obtain-

ing the services of this extremely able assistant. Dr. Keefer is well known in Florida, and his many friends down here and throughout the nation welcome his appointment as a happy omen for medicine and the health of the people.

Sickness Survey Report

In midsummer, results of its first "Sickness Survey" were mailed out by the Washington State Medical Association. This project, the first of its kind in the nation, was sponsored jointly by the association and the University Medical School. The purpose of the survey, held on January 20 of this year, was to obtain an accurate picture of illness as it is actually encountered in private practice in the state.

Numerically, the largest number of visits, 17.5 per cent, was the group not specifically related to sickness, such as those for prenatal and postnatal care, physical examinations and immunizations. A close second was diseases of the respiratory system, which accounted for 17.4 per cent of all visits by physicians.

The cause for visits which ranked third was fractures, sprains and other externally caused damage to the locomotor system. This somewhat surprising result serves to emphasize once again today's high accident rate.

This enterprising state medical association was quick to point out that the high incidence of respiratory illness on January 20 emphasizes the need to repeat the survey, according to plan, four times during the year to allow for seasonal variation. The results of this preliminary survey invite continuation of the project and offer a suggestion to other state associations to do likewise. We wonder how the results of such a survey down here in Florida's southeasternmost corner of the nation would compare with those of our sister state in the far Northwest.

Who Pays the Hospital?

A significant study by the Connecticut Hospital Association, recently completed, brought to light interesting facts and figures reflecting the present trend. Analysis of cases and patient days in the 34 general hospitals in the state for the year ending Sept. 30, 1952, disclosed that only 15 per cent of patient days in Connecticut's community hospitals were paid for by the patients.

Connecticut's Hospital Service (Blue Cross) absorbed the costs of 50 per cent of cases and 45.5 per cent of patient days. Commercial insurance carriers paid 24.5 per cent of the total hospital charges in both categories. City and town welfare budgets were called on to meet costs for only 1.5 per cent of cases and 2.5 per cent of patient days.

How nearly this record conforms to the pattern for the nation as a whole it would be of interest to know in evaluating the great worth, and also the abuses, of hospital insurance.

Role in Korean Medical Rehabilitation

Physicians with the United States Armed Forces in Korea will help in the rehabilitation of South Korea's medical services. In announcing a directive to this effect, the Defense Department explained that uncertainties in Korea require retention of American troops, with the usual ratio of physicians. When their military duties permit, these medical officers will be expected to help in the re-establishment and expansion of medical teaching facilities, hospitals, public health, and "other programs required for the betterment of health and welfare" of the population.

Defense Secretary Wilson emphasized, however, that this new policy may not be used "to justify the retention of medical personnel in the Far East beyond their established tour of duty nor as authority to staff the required military facilities in that area beyond that necessary to carry out the military medical mission. . . ."

Cross-Roads Cancer Seminars

The American Cancer Society, Florida Division, and the Florida State Board of Health, through the local medical societies, are conducting half day sessions on cancer at the following places:

October 6 Ocala
October 7 Arcadia
October 8 Fort Pierce
October 9 Fort Lauderdale

The speaker will be Dr. Douglas H. Riddell of Vanderbilt University School of Medicine.

Similar meetings will be held in West Florida in November:

November 3 Live Oak
November 4 Apalachicola

Two other sessions will be held on November 5 and 6, but the places have not yet been decided. The November speaker will be Dr. Barton McSwain, Vanderbilt University School of Medicine.

Physicians from the surrounding counties are invited to attend these meetings.

Medical District Meetings October 19-22, 1953

Dr. John D. Milton of Miami, chairman of Council, has announced that the programs for the four Medical District Meetings have been completed. These programs, scheduled for October 19, 20, 21 and 22, have been arranged by Dr. Milton with the assistance of the eight councilors. In charge of arrangements for the meetings are: Northwest District, Dr. Francis T. Holland, chairman, and Drs. David J. McCulloch and George S. Palmer, Tallahassee; Northeast District, Dr. Herbert E. White, chairman, St. Augustine; Southwest District, Dr. C. Frank Chunn, chairman, Tampa; and Southeast District, Dr. Willard F. Ande, chairman, West Palm Beach.

Medical District Meetings are designed so that Association officers and members may meet together with a minimum of travel, and so that busy doctors will be away from their practices as short a time as possible. The scientific program of each meeting has been planned to be sufficiently diversified to be of value to general and specializing practitioner alike.

Following the scientific program, officers of the Association will present pertinent and interesting information at each of the meetings. Association officers who will speak include Drs. Frederick K. Herpel, president; Duncan T. McEwan, president-elect; Thomas H. Bates, first vice president; Samuel M. Day, secretary-treasurer; and Shaler Richardson, editor of The Journal. The general sessions will be in charge of Dr. Milton, assisted by a councilor from each district as follows: Tallahassee, Dr. George S. Palmer of Tallahassee; St. Augustine, Dr. Thomas C. Kenaston of Cocoa; Tampa, Dr. Emmett E. Martin of Haines City; and West Palm Beach, Dr. Russell B. Carson of Fort Lauderdale.

Dr. Richard C. Cumming of Ocala will discuss a proposal to establish a memorial to the late Dr. Stewart Thompson. Association members and members of the Woman's Auxiliary are urged to attend.

All sessions begin at 2:30 p.m. on the days indicated on the program below. At 5:45 refreshments will be served by the host societies. Dinner will follow at 6:30. Printed programs will be mailed to all members of the Association prior to the meetings.

Woman's Auxiliary Workshops will be held in connection with the District Meetings. Every doctor's wife is urged to attend these informal sessions. Mrs. James T. Cook, Jr., Marianna, fourth vice president of the Auxiliary, will conduct the meeting in Tallahassee on October 19; Mrs. Samuel S. Lombardo, Jacksonville, first vice president, will preside at the meeting in St. Augustine on October 20; Mrs. Curtis W. Bowman, St. Petersburg, third vice president, will be in charge of the Workshop in Tampa on October 21; and Mrs. Scottie J. Wilson of Fort Lauderdale, second vice president, will conduct the meeting in West Palm Beach on October 22.

Scientific Assemblies — Four Medical Districts
All Meetings — 2:30 p.m.

Monday, October 19, 1953
Tallahassee — A
W. T. Edwards Hospital

Presiding: John D. Milton, Chairman of Council, and William C. Roberts of Panama City for Francis M. Watson of Marianna, Councilor of District 1.

Address of Welcome, Charles F. James, Jr., President, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

"The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery," (by invitation), Francisco A. Hernandez, Miami.

"Paradoxical Skin Response in Rheumatic Activity: A Possible Test," (by invitation), Milton S. Saslaw, Miami.

Tuesday, October 20, 1953
St. Augustine — B
Ponce de Leon Golf Club

Presiding: John D. Milton and William C. Thomas, Jr., of Gainesville, Councilor of District 3.

Address of Welcome, John M. Canakaris, President, St. Johns County Medical Society.

"Diagnosis and Treatment of Intracranial Aneurysms," C. Ashley Bird, Jacksonville.

"The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery," (by invitation), Francisco A. Hernandez, Miami.

Wednesday, October 21, 1953
Tampa — C
Palm Room, Tampa Terrace Hotel

Presiding: John D. Milton and Clyde O. Anderson of St. Petersburg, Councilor of District 5.

Address of Welcome, Arthur R. Knauf, President, Hillsborough County Medical Association.

"Digitalis Brought Up to Date," Edward I. Melich, Bay Pines.

"Paradoxical Skin Response in Rheumatic Activity: A Possible Test," (by invitation), Milton S. Saslaw, Miami.

Thursday, October 22, 1953
West Palm Beach — D
Flotilla Club

Presiding: John D. Milton and Erasmus B. Hardee, Vero Beach, Councilor of District 7.

Address of Welcome, Graham W. King, Jr., President, Palm Beach County Medical Society.

"The Fundamentals of Fluid and Electrolyte Balance (Explanation of Milliequivalents)," George F. Schmitt, Jr., Miami.

"The Treatment of Injuries of the Face and Head," George W. Robertson, III, Miami.

HAVE YOU MOVED ?

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Scientific Program
Eightieth Annual Convention

Doctors desiring to present a scientific paper at the Eightieth Convention of the Florida Medical Association in Hollywood, April 25-28, 1954, should have their applications in by early November.

Doctors are urged to submit any proposed papers together with a brief resume of the subject to be discussed to the Scientific Work Committee at an early date. Your Committee desires to continue the high quality of the programs of previous years and must have many papers and a wide range of subjects from which to choose.

Specialty groups desiring their speakers on the state program must advise the Scientific Work Committee by November, also.

Plans are now underway. So, doctors, mail your applications as soon as possible to Jere W. Annis, M.D., Chairman, Scientific Work Committee, Box 1021, Lakeland, Fla.

STATE BOARD OF HEALTH

Rabies in Florida Bats

Following the report of a child in Hillsborough County being bitten by a bat that had rabies, the State Board of Health has made further investigations into this problem with the cooperation of the Florida Fresh Water and Game Commission. Two hundred and twelve bats have been killed and examined in the Hillsborough-Polk County area. Of this number six have been confirmed by laboratory inoculation as having rabies. Five of the positive cases were found in the Florida yellow bat, and one case was positive in the Seminole or red bat. This bat is a free-living insect feeder; it lives in shrubs and bushes. This is not the colony bat nor the bat that is usually found in chimneys and buildings. Further studies are being made to determine how extensive rabies is among bats in other locations of the state. This is the first time that this disease has been known to be found in Florida among bats.

Q Fever Not Found in Florida

There has been some question as to whether or not Q fever might be prevalent in Florida, since it is fairly common in some of the western states. An investigation has been made through the examination of milk in various areas of the state. Samples from 181 different dairies, representing milk from 18,208 cattle, have been examined, and none of the tests have been reported as positive. This study was made through the cooperation of the State Board of Health and the Micro Biological Institute of the Public Health Service.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alexander, Robert M., Lake City
Brown, J. Brooks, Jacksonville
Christoffers, Donald M., Keystone Heights
Collins, Clyde M., Jacksonville
Marshall, Otis, Penney Farms
Myers, William M., Tampa
Shedd, Robert H., Punta Gorda
Tilles, Samuel, Hollywood

Medical Officers Returned

Dr. Wallace H. Mitchell, who entered military service on June 30, 1951, was released from active duty on June 30, 1953, with the rank of captain (U. S. A. F.). His address is 611 Caroline St., Key West.

DEATHS

Deaths — Members

White, Eston D., Miami ..... July 28, 1953
Couric, Edmonson S., Miami ..... Aug. 22, 1953

Errata

The death of Dr. Joseph S. Murrow of Apalachicola, which occurred on May 28, 1953, was erroneously published in the July Journal as having occurred on May 27, 1953.

STATE NEWS ITEMS

Dr. Louis M. Orr of Orlando, chairman of the A. M. A. Committee on Federal Medical Services of the Council on Medical Service, presided at the Conference on Veterans Medical Care at the Sheraton Hotel, Chicago, on September 1.

Dr. Orr urges all members of the Association to familiarize themselves with the problems on veterans medical care, particularly with reference to non-service-connected disabilities. The A. M. A. has taken a positive stand in opposition to Veterans Administration acceptance of patients with non-service-connected disabilities in V. A. Hospitals. Each member is urged to contact his congressman and senator during the next few weeks while they are in their home communities in order that these legislators may be advised of the opinions their doctors have on this subject.

Ernest Gibson and Harold Parham of the headquarters office were also in attendance at this Conference.

F. M. A. Acting Managing Director Ernest Gibson attended the regional conference on physicians placement service activities sponsored by the A. M. A. Council on Medical Service in Asheville, N. C., on September 19.

The Florida Medical Association State Fair Exhibit will be shown again at the Pensacola Interstate Fair in Pensacola, October 19-25. Free blood typing and blood pressure determinations will be offered. Personnel from the Blood Bank will handle the blood typing, and blood pressure will be taken by hospital nurses. Dr. Walter C. Payne, Sr., is in charge of the exhibit assisted by Drs. Stanley G. Childers and Alvyn W. White. Woman's Auxiliary members will assist in handling the exhibit.

Earmarked "for local medical societies only," the American Medical Association offers four new television shows to be used exclusively by state and county medical societies to spark their public relations programs. These films were designed for airing on public service time over local TV stations — they will not be aired on any national TV network.

Dr. John D. Milton of Miami attended the meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, at The Homestead, Hot Springs, Va., as the invited guest of Drs. H. E. Schmitz, Chicago, and W. F. Mengert, Dallas, Tex.

Dr. James L. Anderson of Miami has returned to his practice after attending meetings of the World Conference on Medical Education in London and the World Medical Association in The Hague.

Dr. Harry M. Edwards of Ocala spoke on polio at a luncheon meeting of the Ocala Rotary Club in August.

Dr. William S. Johnson of Lakeland spoke on polio at an August meeting of the Rotary Club of Auburndale.

Dr. Jack T. Bechtel of Eau Gallie spoke at a meeting of the Eau Gallie Taxpayers Association on a program of flouridation of the municipal water supply as an aid in preventing tooth decay.

Dr. Sidney G. Kennedy, Jr., of Pensacola represented the Escambia County Medical Society in congratulating eight practical nurses and thirteen licensed practical nurses who received certificates for extension courses in nursing at the Pensacola Vocational School.

Dr. Wilson T. Sowder of Jacksonville spoke on the history of mosquito control in Florida at a meeting of the Riverside Lions Club in August.

Dr. Wallace H. Mitchell of Key West is taking a residency in obstetrics and gynecology at the St. Louis City Hospital, St. Louis, Mo. He will return to his practice in several months.

The mid-winter meeting of the Florida Obstetric and Gynecologic Society will be held at the Orange Court Hotel in Orlando, December 5 and 6. The meeting will open at 2 p.m., Saturday and close at noon Sunday. The program will be pre-



AN INVITATION

A cordial welcome awails all members of the Florida Medical Association at the annual meeting of the Southern Medical Association which will be held in Atlanta, October 26-29, 1953.

Forty-seven half day section sessions, general sessions, conjoint meetings, exhibits, and social activities, will make this one of the most complete general medical meetings ever presented to the medical profession. There will be papers presented dealing with every phase of the medical profession. Regardless of how general or how limited a physician's interest may be there will be something on the program to challenge that interest.

Hotel reservations for the Atlanta meeting are being handled by the Housing Bureau. To secure reservations, you should write: Housing Bureau, Southern Medical Association, 801 Rhodes-Haverty Building, Atlanta, Georgia, giving hotel preference, type of reservation, date and hour of arrival and date and hour of departure, name and address.

You are urged to make your plans now to attend this, the outstanding medical meeting of the year for physicians in the south.

Remember, there is no registration fee at meetings of the Southern Medical Association.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM 3, ALABAMA

sented by Drs. Frank R. Lock, Professor of Obstetrics and Gynecology, Bowman Gray School of Medicine of Wake Forest College; Robert B. Greenblatt, Professor of Endocrinology, University of Georgia School of Medicine; and Dr. W. Nicholson Jones, Professor of Gynecology, Medical College of Alabama.

Any member of the Florida Medical Association who includes obstetrics and gynecology in his practice and wishes to be a member of this Society should write for an application to: Dr. J. Champneys Taylor, Secretary, 1022 Park Street, Jacksonville.

Drs. Nicholas A. Tierney of Miami Beach, Homer L. Pearson, Jr., and Paul S. Jarrett of Miami, and Paul H. Jenkins of Daytona Beach were among physicians attending the first World Conference on Medical Education at the British Medical Association House in London, August 22-29.

Dr. John H. Kay of Panama City has been appointed Associate in Surgery at the Tulane University of Louisiana School of Medicine for the 1953-54 session.

Dr. Sherman B. Forbes of Tampa spent several weeks during July and August visiting clinics on the West Coast. For two weeks he attended surgical clinics in San Francisco.

Drs. Hillard W. Willis, Gunnard J. Antell, and Philip J. Chastain, of Coral Gables, Maurice Blinski and Charles Rosenfeld of Miami, and Lewis L. Julien of Miami Beach attended a comprehensive one week course in poliomyelitis at Children's Medical Center in Boston.

Dr. Raymond L. Evans of Miami has been appointed by the Florida Association of Blood Banks as chairman of a group of Florida physicians interested in blood banking operations in this state. Other members of the committee appointed in June are Drs. Samuel M. Day, Jacksonville; Walter C. Payne, Sr., Pensacola; William C. Thomas, Sr., Gainesville; Donald W. Smith, Miami; Robert B. McIver, Jacksonville; and David R. Murphey, Jr., Tampa.

Dr. William C. Williams, Jr., of Delray Beach was the guest speaker at a meeting of the Kiwanis Club of that city in August.

President Frederick K. Herpel of West Palm Beach was the guest speaker at the September meeting of the Marion County Medical Society. He spoke on the activities of the state association and the operation of the headquarters office. Also attending the meeting were Ernest Gibson and Harold Parham from the headquarters office.

Dr. Eugene G. Peek, Sr., of Ocala spoke at a meeting of the Kiwanis Club of Lake Weir in August.

Members of the Florida Medical Association who spoke at the one day scientific session on Heart Disease sponsored by the Florida Heart Association on September 14 in Tampa included: Drs. E. Sterling Nichol of Miami who spoke on "Present Status of Long Term Ambulatory Anticoagulant Therapy in Heart Disease;" Robert A. Broome, Jr., of Orlando, on "Effect of Digitalis on the Q-T Interval;" Solomon D. Klotz, of Orlando, on "Allergy and the Heart in Clinical Practice;" Sidney Davidson of Lake Worth, on "Analysis of Group of Patients with Acute Coronary Artery Disease;" George F. Schmitt, Jr., of Miami, on "The Use of Milliequivalents in Heart Disease;" and H. Phillip Hampton of Tampa, on "Current Status of Anticoagulant Therapy."

Drs. Reuben Rochkind, Francisco A. Hernandez, Bruce M. Hogg and Milton S. Saslaw, all of Miami, spoke on heart disease in children to the Dade County school teachers of exceptional children on June 16. Dr. Rochkind spoke on "Rheumatic Fever and Heart Disease;" Dr. Hernandez, on "Congenital Heart Disease;" Dr. Hogg, on "Cardiac Surgery in Children;" and Dr. Saslaw, on "Research in Pediatric Cardiology."

Dr. Robert C. Welsh of Miami has returned to his practice after spending two weeks in New York observing the latest advances in eye surgery.

Dr. Egbert V. Anderson of Pensacola spoke on the doctors' and nurses' exchange register at a meeting of the Rotary Club of Pensacola.

Dr. Clarence M. Sharp of Jacksonvile was elected vice president of the American Trudeau Society at the annual meeting of the Society in Los Angeles in May.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

LOST: One old gold earring with small diamond during Annual Convention Hollywood Beach Hotel. Very valuable to owner. Reward. Write William H. Grace, M.D., 71 First Street, Fort Myers, Fla.

WANTED: Association with group, industry, institution; Fort Lauderdale area. Clinical and administrative experience. Write 69-98, P. O. Box 1018, Jacksonville, Fla.

ENT MAN: Wanted by Coral Gables group. Eventual partnership. Excellent opportunity. Hospital privileges. Write 69-99, P. O. Box 1018, Jacksonville, Fla.

LOCATION: Established thirty year EENT lucrative practice for sale. Would rent office with or without equipment. One block from ocean. Write L. W. Glatzau, M.D., 530 North Grandview, Daytona Beach, Fla.

WANTED: M.D. for general practice in Mulberry, Fla. Address all inquiries to the City Council, Mulberry, Fla.

FOR SALE: Late model STANDARD combination radiographic-fluoroscopic 100 MA x-ray machine complete with tubes, control stand, etc. Like new in every respect. A real buy for someone. Tel. 98-1770, 5922 Beach Blvd., Jacksonville, Fla.

WANTED: Pediatrician, preferably young, available December 1953, to occupy a new medical building in growing area of Fort Lauderdale. For details write: W. J. Glenn, M.D., 1106 E. Broward Blvd., Fort Lauderdale, Fla.

SITUATION WANTED: Physician, age 39, white, married, Protestant, Category 4, has Florida license, would like to find a satisfactory location in that state to practice Obstetrics and Gynecology. Graduate of the University of Virginia, trained at Duke University, and certified by the American Board of Obstetrics and Gynecology. Write 69-100, P. O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: 29, Florida license, getting out of Navy December, wishes to join group practice. Write 69-101, P. O. Box 1018, Jacksonville, Fla.

1953 Medical District Meetings

"A", Tallahassee	October 19
"B", St. Augustine	October 20
"C", Tampa	October 21
"D", West Palm Beach	October 22

COMPONENT SOCIETY NOTES

Dade

The regular monthly meeting of the Dade County Medical Association was held on September 1. An indoctrination course for provisional members was held, and Dr. Donald F. Marion spoke on The Bulletin. No scientific program was presented.

Lake

At the regular September meeting of the Lake County Medical Society a panel discussion on "Current Local Problems" was held with members of the society participating. The number of members in attendance set an all time record.

Marion

President Frederick K. Herpel, West Palm Beach, was guest of honor at the regular monthly meeting of the Marion County Medical Society in Ocala on September 15. Dr. Herpel explained to the society members and members of the Woman's Auxiliary some of the activities of the state association and the operation of the headquarters office. Also present were Ernest Gibson and Harold Parham from the Association staff.

Pinellas

The regular monthly meeting of the Pinellas County Medical Society was held on October 5 at the Lakewood Country Club, St. Petersburg.

Suwannee

The Suwannee County Medical Society is sponsoring an exhibit at the Suwannee County Fair at Live Oak, October 19-24, according to announcement by Dr. Edward G. Haskell, Jr., Branford, secretary of the Society. The American Medical Association's display on cancer has been obtained for the event through the F. M. A. Bureau of Public Relations.

OBITUARIES

Luther William Holloway

Dr. Luther William Holloway of Jacksonville died in a local hospital on May 7, 1953, shortly after suffering a cerebral hemorrhage at his residence. He was 64 years of age.

A native of Florida, Dr. Holloway was born at Lacrosse on March 7, 1889. He received his academic education at the University of Florida and his medical training at the Tulane University of Louisiana School of Medicine. He was awarded the degree of Doctor of Medicine in 1914 and then served an internship at the Touro Infirmary in New Orleans. His fraternities were Alpha Tau Omega and Chi Phi.

During World War I, Dr. Holloway served as a first lieutenant in the medical corps of the United States Army. For one year before and one year after this service he practiced medicine in Carabelle. He then located in Jacksonville in 1922 and began his career in the field of pediatrics. Locally, he was active professionally and in the civic and social life of the city for 31 years. He was a life member of the Florida Yacht Club. One of the earliest members of Ye Mystic Revellers, he was a member of the board for 25 years and served both as captain and king. His church affiliation was with the Riverside Baptist Church for 29 years, and he was an active member up to the time of his death.

His untimely death ended many years of service as chief of the Department of Pediatrics at St. Vincent's Hospital, St. Luke's Hospital and Duval Medical Center. Also, he was a member of the visiting staff of Riverside Hospital and Hope Haven Hospital as well as chief of the medical staff of the Children's Home Society in Jacksonville and chief pediatrician at St. Mary's Home.

As Florida's first pediatrician, Dr. Holloway was honored less than a year ago with a testimonial dinner by the Florida Pediatric Society. He served as the first Florida chairman of the American Academy of Pediatrics and was a clinical lecturer on pediatrics at the Southern Pediatric Seminar, Saluda, N. C.

Dr. Holloway was a member and a past president of the Duval County Medical Society. For 30 years he was a member of the Florida Medical Association, serving officially in various capacities, and he also held membership in the American Medical Association. He was a member and past counselor of the Southern Medical Association.

Surviving are the widow, Mrs. Jean O'Leary Holloway, and his mother, Mrs. Idella Holloway, both of Jacksonville; five daughters, Mrs. S. A. Freel, Jr., of Jacksonville, Mrs. Louis F. Bein,

Jr., of Berthoud, Colo., Mrs. Howard H. Sanderson of Red Bluff, Calif., Miss Catherine Holloway and Miss Penelope Holloway of Jacksonville; six sons, L. W. Holloway, Jr., of Jacksonville, John Pearse Holloway of Houston, Tex., Cpl. Lawrence Misbet Holloway of the United States Army in Korea, Pfc. Robert S. Holloway of the United States Army, Panama Canal Zone, and Samuel Norris Holloway and Michael Covert Holloway of Jacksonville; three sisters, Mrs. Shepherd Clark and Mrs. John Lloyd Misbet of Jacksonville and Mrs. Milton Parker of Tallahassee; one brother, Lewis Cone Holloway of Jacksonville, and 13 grandchildren.

John Andrew Simmons

Dr. John Andrew Simmons of Arcadia died suddenly of a heart attack at the home of his daughter, Mrs. W. Harry Dean, in Coral Gables on April 25, 1953. Apparently in excellent health, he had gone to the East Coast earlier that day to attend the annual meeting of the Florida Medical Association, of which he was a past president. He was 75 years of age.

Dr. Simmons received his medical training at the University of Arkansas School of Medicine, where he was awarded the degree of doctor of Medicine in 1905. Two years later he came to Florida and located in Arcadia. Except for an interim of four years spent in Miami in the twenties, he continued to engage in the general practice of medicine and surgery in Arcadia for 46 years. This beloved pioneer physician was through the years well known throughout the state and was active in the affairs of his community. At the time of his death he was chairman of the board of stewards of the Arcadia Methodist Church.

In 1912 Dr. Simmons realized an early ambition by establishing the 12 bed Simmons Sanatorium, which he operated with the assistance of his wife, who was a trained nurse. This hospital, which a decade later became the Arcadia General Hospital, was the first institution of the kind south of Lakeland and served a wide area extending across the state from coast to coast.

Since 1909 Dr. Simmons had been a member of the Florida Medical Association and in 1927 served as its president. He was also a past president and a life member of the Desoto-Hardee-Highlands-Glades Medical Society and held membership in the American Medical Association.

Surviving are the widow, Mrs. Erma T. Simmons of Arcadia; two sons, John A. Simmons, Jr., of Miami, and J. Dibrell Simmons of Galveston, Texas; one daughter, Mrs. Mabel Simmons Dean; a stepson, Ralph Lambert of Miami; a brother, J. Will Simmons, and a sister, Mrs. Lula Simmons Ingram, both of Tampa.

Clyde Francis Smith

Dr. Clyde Francis Smith of Miami Beach died at his home on Feb. 28, 1953, while preparing to leave on a house call. He was 57 years of age.

The son of Dr. Alfred Clark Smith, Dr. Smith was born in Washington, Pa., on March 20, 1895. Upon graduation from Ohio Wesleyan University he pursued his medical training at Jefferson Medical College of Philadelphia, where he was graduated in 1921. After he completed an internship at Presbyterian Medical Center in Pittsburgh, Pa., he entered the practice of medicine with his father, an orthopedic surgeon of Brownsville, Pa. In 1933, he moved to Washington, N. J. There he organized, owned and headed the Smith General Hospital and engaged in a full general practice including both surgery and obstetrics. Disposing of his New Jersey holdings in 1939, he came to Florida and opened an office in Miami Beach. At that time he limited his practice to internal medicine.

Dr. Smith, while still a medical student, served in World War I, and during World War II he was post surgeon at the Ream General Hospital in Palm Beach and later at the Key West Army Base. Upon his discharge from the service with the rank of major, he resumed his Miami Beach practice. Devoted to his practice and his family, he led a full but quiet life. He was a communicant of St. Joseph's Church at Surfside and held membership in the Coral Gables Country Club.

A member of the Dade County Medical Association, Dr. Smith was also a member of the Florida Medical Association and the American Medical Association.

Early in his career, Dr. Smith was married to Mary Elizabeth Schilp, a widow with three sons. To this group was added another son, Dr. Clyde F. B. Smith, serving as a first lieutenant in the United States Army at the time his father met death while endeavoring to maintain his son's practice along with his own. One of these sons

met accidental death on his honeymoon in 1940, and another is Dr. John P. Schilp, Jr., of Hialeah.

Joseph Perez

Dr. Joseph Perez of DeLand died at Fish Memorial Hospital in that city on March 6, 1953. He was 60 years of age.

Born in Valencia, Spain, on July 4, 1892, Dr. Perez received his medical training at the University of Valencia, where he was awarded the degree of Doctor of Medicine by the Valencia Faculty of Medicine and Surgery in 1916. From the University of Madrid he received the D.M.Sc. degree in 1919. During World War I, he volunteered and served as a first lieutenant with the French Army.

On a fellowship, Dr. Perez went to the Mayo Clinic, Rochester, Minn., in 1921. For the next nine years he served as resident surgeon for several large hospitals in New York City. From 1925 to 1930 he was chief resident surgeon in Cumberland Hospital, Brooklyn, N. Y., where he engaged in cancer research. From 1930 until he came to Florida he was associate surgeon for a number of hospitals in the Greater New York area and was affiliated with the Kings County Medical Society.

In 1950 Dr. Perez came from New York City to Florida to reside and located in DeLand. He was a thirty-second degree Scottish Rite Mason, a member of the Morocco Temple of the Shrine, and a member of the Elks Lodge.

Dr. Perez was a member of the Volusia County Medical Society and had held membership in the Florida Medical Association for three years. For many years he had been a member of the American Medical Association.

Surviving are the widow, Mrs. Anna Perez, and a daughter, Sylvia, of DeLand, and a son, Richard, of New York City.

Henry Walters Pracht

Dr. Henry Walters Pracht of Miami Beach died suddenly of a heart attack on May 13, 1953. He was 49 years of age.

A native of West Virginia, Dr. Pracht was born at Grafton on Sept. 6, 1904. He received his premedical training at the University of West Virginia and was awarded the degree of Doctor of Medicine by the University of Pittsburgh School of Medicine in 1928. After completing an internship at the West Penn Hospital in Pittsburgh in 1929, he served residencies at Passavant, Shadyside, West Penn and St. Margaret's hospitals in that city.

Since 1945, Dr. Pracht had engaged in the practice of surgery in Miami Beach. Locally, he was a member of the Rod and Reel Club, and he held membership in the Theta Chi literary fraternity. He was a talented musician and the master of several different musical instruments. For several years he was saxophonist with Paul Whiteman's Orchestra. A man of many hobbies, he especially enjoyed fishing and building model railroad equipment.

Dr. Pracht was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He also held membership in the International College of Surgeons.

Meyer J. Glick

Dr. Meyer J. Glick of Miami Beach died at his home on May 24, 1953. He was 59 years of age.

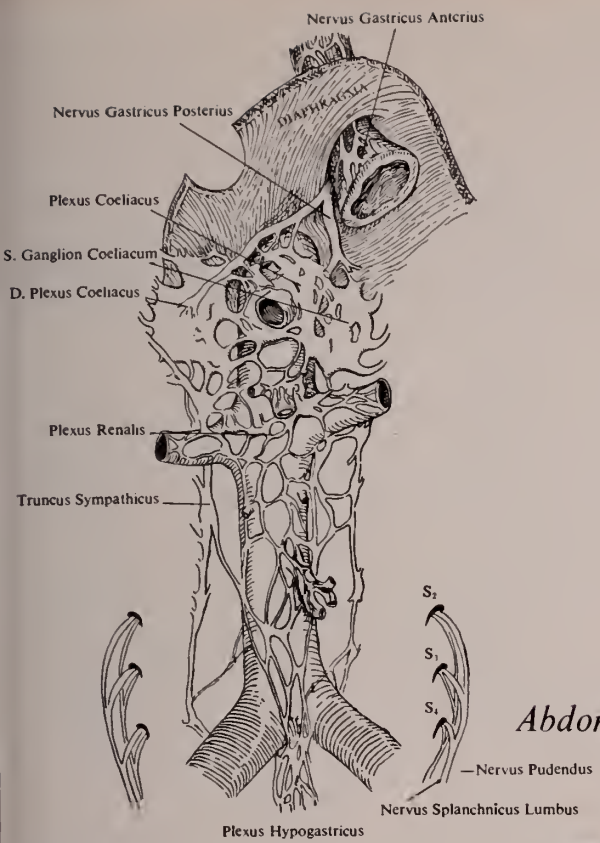
Born in Roumania in 1893, Dr. Glick received his early education in his native land. At the age of 17 he came to America and settled in Detroit, Mich. There he began the study of medicine and in 1925 received the degree of Doctor of Medicine from Wayne University College of Medicine. After completing an internship, he engaged in the general practice of medicine in Detroit.

Because of ill health he later came to Florida and located in Miami Beach. In 1944 he was well enough to resume his practice and entered the practice of internal medicine there.

Among his varied interests was a comprehensive knowledge of the arts and sciences. A Hebrew scholar of note, he was a recognized authority on various aspects of Hebrew scholarship. He often lectured and wrote on Hebraic and Jewish subjects.

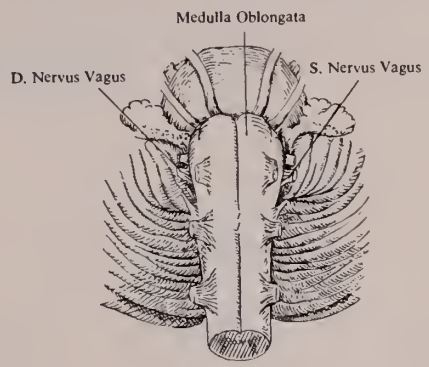
Dr. Glick was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was also a member of the American Congress of Physical Medicine and Rehabilitation.

Surviving are one son, Joseph Glick of Detroit; one daughter, Mrs. Naomi Glick Adams of San Diego, Calif.; and six grandchildren.



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It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthīne) Bromide in Gastroenterology, J.A.M.A. *147*:1620 (Dec. 22) 1951.

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Integration

Each month since May, I have discussed a way in which Study Group could be utilized by the parliamentarian as well as by chairmen of various committees, such as nominating, public relations and legislation. This month I would like to point out how the program chairman could step in and integrate the effort of all and come through with a stimulating, beneficial program herself.

This could be achieved by meeting with the study group chairman and planning a program for the year, featuring a different chairmanship each month. Each chairman, with the committee which she should have, could through study group get material on her subject and work out an entertaining constructive evening.

We like inter-organizational participation anyway and such a plan would be conducive to friendliness. It would create opportunities to really find out about the function of the group and would have the confidence-giving advantage Dale Carnegie advocates in his course on Public Speaking.

One example is a skit on parliamentary law featuring the Helen Hoagensen type of humor on clubs without order, followed by a sample of how to make motions and participate generally in dis-

cussion. This kind of program can be entertaining as well as constructive.

The variations are unlimited. This could not fail because I am certain that a doctor's wife has the background, education and ingenuity to produce an interesting hour once a month if she is called upon to do so. If the group enters into the spirit of the thing, she will want to.

Mrs. C. Robert DeArmas

Woman's Auxiliary Workshop

Tallahassee	Oct. 19, 1953
St. Augustine	Oct. 20, 1953
Tampa	Oct. 21, 1953
West Palm Beach	Oct. 22, 1953



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From where I sit
by Joe Marsh

An Honest Night's Sleep

Slim Johnson, just back from a business trip, tells about a hotel he stayed at one night.

"I arrived in town late and went right to the hotel. There was no clerk at the desk, but there was a sign that said: 'Have gone to bed. Rooms $3. Please take a key. Pay when you leave. Sleep Well.'

"Upstairs, the room was real clean, the bed comfortable and I slept like a log. Came down in the morning—still no clerk. So I left three dollars at the desk and went on. Can you imagine folks that trustful?"

From where I sit, running a hotel on the honor system shows a real trust in people. And people always appreciate being trusted. Letting the other fellow follow his profession without interference is one way of trusting your fellow citizens. So is your regard of my *liking an occasional glass of beer. You may prefer buttermilk, but let's hope neither of us "register" a complaint against the other.*

Joe Marsh

Copyright, 1953, United States Brewers Foundation

BOOKS RECEIVED

Hospital Staff Appointments of Physicians in New York City. Hospital Council of Greater New York. Pp. 151. Price, $3.25. New York, The Macmillan Company, 1951.

The report of a two year study of a committee of the Hospital Council of Greater New York is presented in this book. Although the study was limited to the five boroughs which comprise New York City, the findings and conclusions will be useful to many other communities.

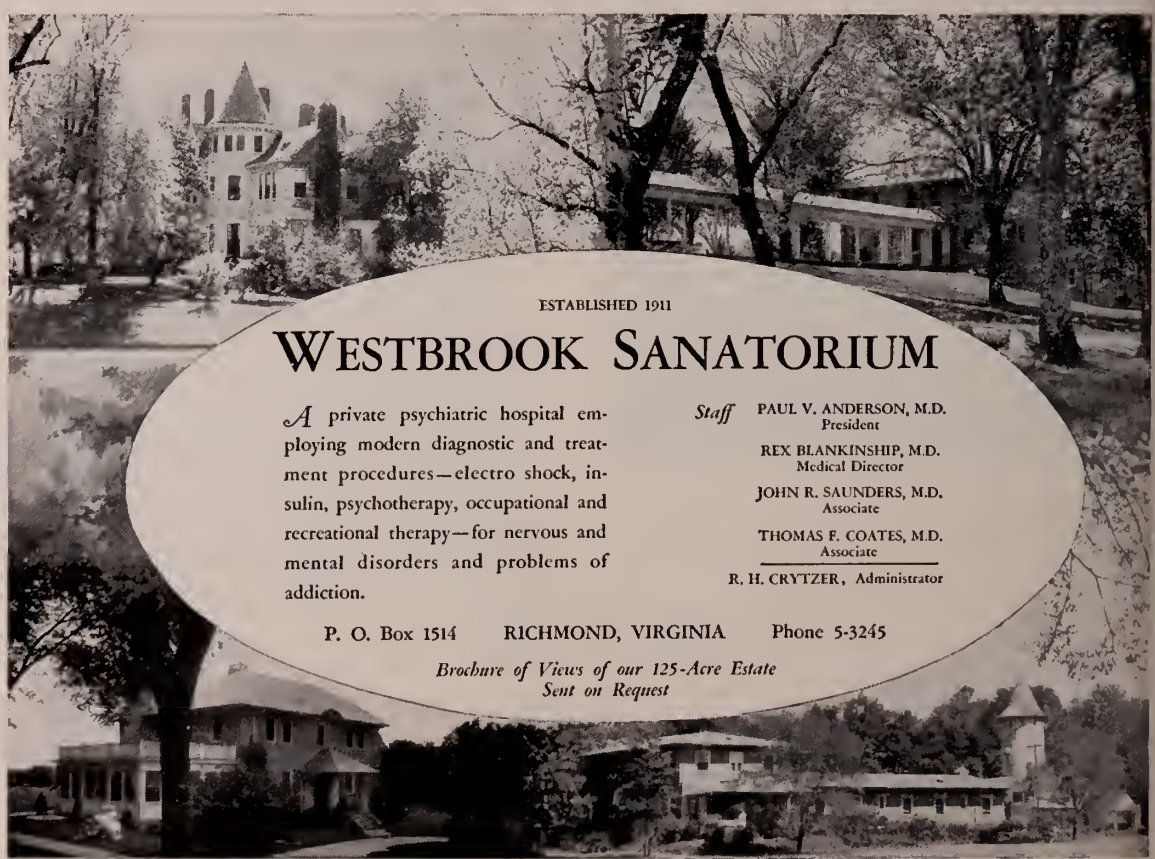
It is pointed out that the matter of hospital appointments is important from a medical as well as a community health standpoint. A community whose citizens are served by physicians with staff appointments receives better care since hospital affiliation allows physicians an opportunity to further their medical education and keep current with up-to-date practices.

At the beginning of the study, the following questions were posed: What should be the responsibility of hospitals to the physicians in a community? What should be the proper proportion of physicians having staff appointments? How many physicians should be on staffs of individual hospitals? How many physicians should have privileges for admission of private and semiprivate patients? The Hospital Council endeavors to suggest answers to these and many other questions involved in the problem of hospital staff appointments for practicing physicians.

Back Down the Ridge. By W. L. White. Pp. 182. Price, $3.00. New York, Harcourt, Brace and Company, 1953.

Discussed in human rather than in medical terms, this chronicle of the immediate and long term treatment of the wounded of the Korean war begins with a study of eleven men. Here in stark and documentary reality is a "litter-level" view of how they were wounded, what they did and said, how they got back down the ridge, how they felt as they were carried to battalion first aid stations or moved on to a Mash (Mobile Army Surgical Hospital), thence through various stages to Tokyo and the States. Here, too, is a description of the miraculous advances in medical field service which are saving the lives of casualties who would have died in any other war, and there is an account of the treatment and training in the States accorded a typical amputee. In addition, there is, in part, the story of our allies — among them the indomitable Turks, the valiant and increasingly effective ROKs.

The author is the son of the late William Allen White, famous newspaper man, editor and grass roots philosopher. Following in his father's footsteps, William Lindsay White has developed a special gift for capitalizing on particularized information given him, for showing "how enormous circumstances work out pettily in relation to the plain individual." As he unfolds the "choral story" of infantry-



men, doctors and nurses in the vivid and exciting manner of his *They Were Expendable,* there emerges another figure, "the average American boy, just under 20, who was pulled from his malted milks and basketball scores to be wounded in Korea. Much of this story is now of him and what he thinks, of his buddies, his weapons, his leaders, his allies and their enemies, and of this curious little war which all were sent out to fight."

A Century of Medicine 1848-1948. The History of the Medical Society of the State of Pennsylvania. Edited by Howard Kistler Petry, M. D. Pp. 404. Harrisburg, Pa., The Medical Society of the State of Pennsylvania, 1952.

This book is a particularly notable contribution to the history of medicine in this country. As stated in the preface, Pennsylvania has been not only the Keystone State of the Union in its political history, but also in its medical history. It has much to be proud of in its medical accomplishments and innumerable firsts adorn the pages of its medical history. The history is properly presented as a research document and a compilation of factual data, making it an authoritative addition to the annals of medicine.

The centennial year of organized medicine in Pennsylvania made an appropriate time to survey the activities of the medcial profession in that commonwealth, styled "the birthplace of American Medicine" by Dr. Edward L. Bortz, Chairman of the Centennial Celebration Committee and latest of ten Pennsylvanians to serve as president of the American Medical Association in its century of history. The noble heritage of The Medical Society of the State of Pennsylvania when it was organized in 1848 and the constant leadership through the years exerted by Pennsylvania men of medicine make the recording of the century-long history of this organization an achievement of importance on which it is to be congratulated.

Doctor in the House. By Richard Gordon. Pp. 186. Price, $2.75. New York, Harcourt, Brace and Company, 1953.

Holding the warmth of nostalgic memory throughout, this tale of the life, loves and labors of an English medical student of contemporary times is replete with humor — wry, reserved, smilingly irreverent and at times attaining the status of sheer ribald genius. Richard Gordon, a 30 year old London doctor, takes the reader with him through his six years of training in a London hospital. Not in a generation or more in America has medicine been taught as related here, and one wonders how the archaic and mysterious process "transforms boisterous louts or diffident fledglings into urbane practitioners."

Whatever the real name of the physician-humorist-author, he takes his place among the few top notch younger British humorists. Possessed of a style wholly individual and also of "the brightest lunacy," he peoples the pages with Pickwickian characters. Perhaps many physicians would find in this "raffish account" of Dr. Gordon's medical education what Florida's own surgeon-novelist saw in it, as expressed in his review of the book in the New York Times. "From cover to cover," writes Dr. Frank G. Slaughter, "Dr. Gordon's book is rich stuff, distinctly off the beaten path of humor. Like battlefield humor, it takes its sharp flavor from the constant battle against death of which it is a part. . . . One is almost sorry when Dr. Gordon graduates and Grimsdyke forswears the pleasures of academic failure for marital bliss. For this reader's money, 'Doctor in the House' is pretty wonderful entertainment."

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Dr. Homer L. Pearson, Jr., Secretary of the State Board of Medical Examiners, has reported that of the 243 applicants who took the examination of the Board, held June 29 and 30, 1953, in Jacksonville, 167 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 167 successful applicants follow:

Allen, James Norman, Tampa (Harvard 1949)

Baehr, John Jacob, Pensacola (Tulane 1945)
Balli, Carl Eugene, Miami (Geo. Washington 1953)
Beeler, Robert Verlin, Jr., Knoxville, Tenn. (Vanderbilt 1949)
Berkey, William E., Coral Gables (New York Med. Coll. 1919)
Bevinetto, Jack Richard, Newark, N. J. (Laval 1929)
Binder, Charles Israel, Newark, N. J. (Minnesota 1939)
Blanton, James Lewis, Clifton Springs, N. Y. (Virginia 1924)
Bovill, John Chesley, Durham, N. C. (Wayne 1943)
Brashear, Billy, Grundy, Va. (Louisville 1951)
Broussard, Elsie Rita, Pensacola (Louisiana State 1944)
Brown, Harry William, St. Petersburg (Tufts 1950)
Brown, Robert Louis, Evansville, Ind. (Indiana 1944)
Brown, Warren Joseph, Key West (Ohio State 1949)
Bulfin, Matthew Joseph, Chicago (Loyola 1947)
Burdette, Marvin Garten, Huntington, W. Va. (Virginia 1946)

Carmichael, Lynn P., Buechel, Ky. (Louisville 1952)
Carter, Charles Herschel, Gainesville (Tennessee 1942)
Cohen, Maurice, Tampa (Tulane 1952)
Cohen, Sanford Irwin, Miami Beach (Chicago Med. Sch. 1952)
Crissey, Raymond Thomas, Tampa (Wayne 1945)

Darty, Warren Gamaliel, Lake Wales (Tulane 1951)
David, Noble Jonathan, Jacksonville (Duke 1952)
Davis, Charles Elmer, Williamsburg, Ky. (Louisville 1952)
Deal, Dwayne Lee, Tampa (Tennessee 1950)
Dobert, Philip, Batavia, O. (Cincinnati 1947)
Doty, James Robert, Gary, Ind. (Rush 1926)

Echelman, Gilbert Marshall, Orlando (New York U. 1953)
Eckel, Edward Jacob, Everglades (Cornell 1910)
Edmiston, John McWhorter, Warrington (Temple 1944)
Ellenbogen, Nina Claire, Miami (Albany 1953)
Ellis, Donald Stephen, Wellesley, Mass. (Cornell 1948)
Evans, William Canfield, Jr., Gainesville (Duke 1953)

Farrior, Richard Thomas, Tampa (Duke 1949)
Fazio, Frank Valentino, St. Augustine (Emory 1953)
Fisher, John Jacob, Jacksonville (Pittsburgh 1948)

Garrett, Harvey Edward, Pensacola (Emory 1953)
Goodrich, Howard Brant, Winter Park (Harvard 1922)
Gordon, Howard Leo, Daytona Beach (Geo. Washington 1953)
Gottfried, Bernard, Flushing, N. Y. (Virginia 1942)
Gottlieb, Jacques Simon, Miami (Harvard 1933)
Gould, Martin Geoffrey, Miami (Royal Coll. P & S, England 1943)
Greenberg, Morris William, Brooklyn (New York Homeo. 1931)

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GYNECOLOGY—Intensive Course, Two Weeks, starting October 19. Vaginal Approach to Pelvic Surgery, One Week, starting November 2.

OBSTETRICS—Intensive Course, Two Weeks, starting November 2.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting October 12. Gastroenterology, Two Weeks, starting October 26. Gastroscopy, Two Weeks, starting November 2.

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Greene, Joseph Lewis, Logan, W. Va. (Western Reserve 1935)
Grenell, Walter Burt, Memphis, Tenn. (Northwestern 1948)
Guerin, Bernard K., Coral Gables (Geo. Washington 1950)
Gunn, Samuel Albert, Surfside (Illinois 1937)

Hall, Maxwell Felton, Jr., Emory University, Ga. (Emory 1953)
Hatt, William Swazey, Key West (Harvard 1948)
Havranek, James C., River Forest, Ill (Illinois 1938)
Haynes, Ruth Calladine, Sanford (Harvard 1952)
Haynes, Walter Marion, Jr., Sanford (Harvard 1951)
Henney, Patricia Mary, McKees Rocks, Pa. (Pittsburgh 1952)
Herbert, Carl Morse, Jr., Manasquan, N. J. (Johns Hopkins 1946)
Herbert, Victor Daniel, Washington, D. C. (Columbia 1952)
Herring, Howard Egbert, Jr., Durham, N. C. (Duke 1947)
Hodge, Edgar Bruce, Miami (Texas 1952)
Hodgins, Thomas Earl, Jr., Jacksonville (Vanderbilt 1951)
Houts, Joseph Claude, Miami (Minnesota 1952)
Howard, Frank Albert, Green Cove Springs (Washington 1950)
Huber, Erwin Theodore, Fort Pierce (St. Louis 1935)
Hubbard, David Stroud, Atlanta, Ga. (Emory 1953)
Humphreys, John Wesley, Crawfordsville, Ind. (Indiana 1936)

Inman, Charles William, St. Petersburg (Northwestern 1950)
Ireland, Treadwell Lewis, Westburg, L. I., N. Y. (Long Island Med. Coll. 1939)

Johnson, Maurice Nathaniel, Warrington (Minnesota 1947)
Joiner, Horace Greely, Douglas, Ga. (Georgia 1944)
Jonas, Saul Stanley, Miami Beach (Emory 1953)
Jones, Grey, Fort Pierce (Michigan 1925)
Jones, Warren Richard, Warrington (U. of Chicago 1951)
Juniper, Kerrison, Jr., Atlanta, Ga. (Emory 1949)

Katz, Harry Meyer, Montgomery, Ala. (Alabama 1950)
Kidder, Richard Francis, Perry Point, Md. (Jefferson 1949)
Killinger, Raymond Robert, Jr., Jacksonville (Pennsylvania 1953)
Kish, Alex, Live Oak (Illinois 1951)
Kiszka, Edward Francis, Emory University, Ga. (Emory 1953)
Knight, James Allen, St. George, S. C. (Vanderbilt 1952)
Kraeft, Nelson Herbert, Tallahassee (Vanderbilt 1943)
Kubek, Robert Bruce, Fort Lauderdale (Duke 1944)

Lafferty, Arland Wayne, Hope, Ark. (Arkansas 1952)
Lambeth, Samuel Summerfield, Maryville, Tenn. (Virginia 1939)
Lancaster, James William, Coral Gables (Tulane 1950)
Lauray, Daniel Leon (Col.), Jacksonville (Meharry 1953)
Leavenworth, William Miller, Orlando (Western Reserve 1946)
Leech, Clifton Briggs, Providence, R. I. (Boston 1919)
Levison, Herman, Hollywood (New York U. 1908)
Lichtblau, Philip Oscar, North Bergen, N. J. (Tulane 1945)
Lidd, David, Miami (New York U. 1950)
Long, Harold Wescott, Carrabelle (Georgia 1936)
Lowry, Mary Ellen, Miami (Alabama 1952)
Lucas, Howard Charles, Winter Haven (Cornell 1951)
Luer, Carlyle August, St. Louis, Mo. (Washington 1946)

MacKenzie, Malcolm, Dunedin (South Carolina 1952)
McCain, George Holmes, Tallahassee (Tennessee 1936)
McElwain, Jack White, Philadelphia (Syracuse 1945)
McNicholas, Anthony Joseph, Century (Tennessee 1947)
McReynolds, William Uriel, Ann Arbor, Mich. (Northwestern 1951)

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Manganiello, Louis Ottone, Atlanta, Ga. (Maryland 1942)
Mann, Ronald Jason, Miami (Tulane 1953)
Marston, Warren Galbreath, Fort Pierce (St. Louis 1929)
Matthews, Edward John, Staten Island, N. Y. (Middlesex 1939)
Mattson, Daniel Henry, Tampa (Tennessee 1952)
Meeko, Robert Franklin, Jacksonville (Cincinnati 1943)
Middleman, Isadore Carl, St. Louis, Mo. (St. Louis 1933)
Moore, William Finley, Jr., Lake City (Georgia 1949)
Morse, Alexander Edison, Jr., Miami (Tufts 1951)
Mott, Richard Henry, Jr., Auburndale (Geo. Washington 1950)
Murr, Claude Viveon, Jr., St. Petersburg (Tennessee 1951)

Nelson, Richard Allan, Newark, N. J. (Pittsburgh 1942)
Nobo, Jacinto Luis, Miami (Havana 1945)

Packard, John Mallory, Pensacola (Harvard 1945)
Page, George Edward, St. Petersburg (Wayne 1952)
Parker, John Henry, Jr., Perry (Tulane 1953)
Paty, Philip Behenna, Covington, Ga. (Emory 1952)
Peck, George Charles, Brooklyn (Maryland 1953)
Permesly, Harry Michael, Miami Beach (Chicago Med. Sch. 1945)
Perry, Benjamin Franklin, Jr., Clermont (Georgetown 1949)
Pfeiffer, John Bernard, Jr., Durham, N. C. (Cornell 1942)
Pilcher, John Judson, Jr., Wrens, Ga. (Georgia 1952)
Polk, John Wood, Helena, Ark. (Arkansas 1945)

Race, George Justice, Durham, N. C. (Texas 1947)
Raim, Jerome Abraham, Miami (Western Reserve 1952)
Richardson, William Woodrow, Panama City (Tulane 1951)
Ringwald, Clifford Wallace, Coral Gables (Marquette 1946)
Rippy, Wilson Crunk, Jr., Atlanta, Ga. (Emory 1952)
Rowland, Harold Thomas, Miami (St. Louis 1953)
Rundles, William Robert, Jacksonville (Cincinnati 1948)

Shapiro, Herman S., Pensacola (Vanderbilt 1944)
Shaw, John William, Jacksonville (Jefferson 1952)
Shehee, Walter Hendrick, Bonifay (Emory 1952)
Sherman, Albert Maxwell, Weehawken, N. J. (Bern U. 1938)
Shippen, Eugene Rodman, Jr., Winter Park (Hahnemann 1935)
Shivers, Olin Grigsby, Jr., Chipley (Cornell 1948)
Shutts, Paul Eugene, New Orleans (Virginia 1951)
Silverstein, Daniel Lewis, Tampa (Maryland 1948)
Simpson, Dazelle Dean (Col.), Miami (Meharry 1950)
Simpson, George Augustus (Col.), Miami (Meharry 1950)
Smith, Ernest Griggs, Jr., Atlanta, Ga. (Johns Hopkins 1943)
Smoak, Henry Elton, Jr., Tampa (Alabama 1949)
Solomon, Henry Doyle, Jr., St. Petersburg (Emory 1953)
Stanley, Gordon Douglas, Sanford (Duke 1951)
Stansbury, Thomas Conley, Jr., Sarasota (Louisville 1946)
Staton, Ted Logine, Jr., Orlando (Emory 1953)

Thomas, Launey Jonathan, Jr., Jacksonville (Emory 1953)
Trope, Robert Jay, West Palm Beach (Louisville 1947)
Troutman, Erwin W., Miami (Ohio State 1920)

Vinci, Samuel Leonard, Cleveland Heights, O. (Ohio State 1938)

Walker, James William, Jacksonville (Tennessee 1953)
Ward, Jack Pearce, Altamonte Springs (Medical Evangelists 1952)
Warden, Cyrus Ely, Amityville, N. Y. (Columbia 1932)
Waugh, William Chastain, Dunnellon (Louisville 1938)
Weaver, Thomas DeWitt, Tucker, Ga. (Georgia 1953)
Weigel, Walter Weber, Jacksonville (Emory 1953)
White, Bradford Carson, Jacksonville (Hahnemann 1953)
White, Thomas Blase, Surfside (Ohio State 1952)
Whiteman, Harold Wilson, Atlanta, Ga. (Emory 1951)
Widran, Jerrold, Chicago (Illinois 1950)
Wilkison, Earl Edward, Clewiston (Virginia 1945)
Willard, Benjamin Charles, Jr., Miami (Tulane 1953)
Williams, Jean Babington, Jr., Atlanta, Ga. (Duke 1953)
Williams, Jess Lee, Jr., Jacksonville (Duke 1952)
Williams, Salvador A., Canal Point (Natl. Homeo. MS, Mexico 1947)
Wills, Silas Angier, Tampa (Emory 1953)
Wilson, Frank Lyndall, Jr., Atlanta, Ga. (Emory 1952)
Wolford, John Leland Joseph, Miami (St. Louis 1951)
Wright, Peter Burum, Augusta, Ga. (Georgia 1920)
Wyman, Benjamin Francis, Jr., Fort Pierce (South Carolina 1950)

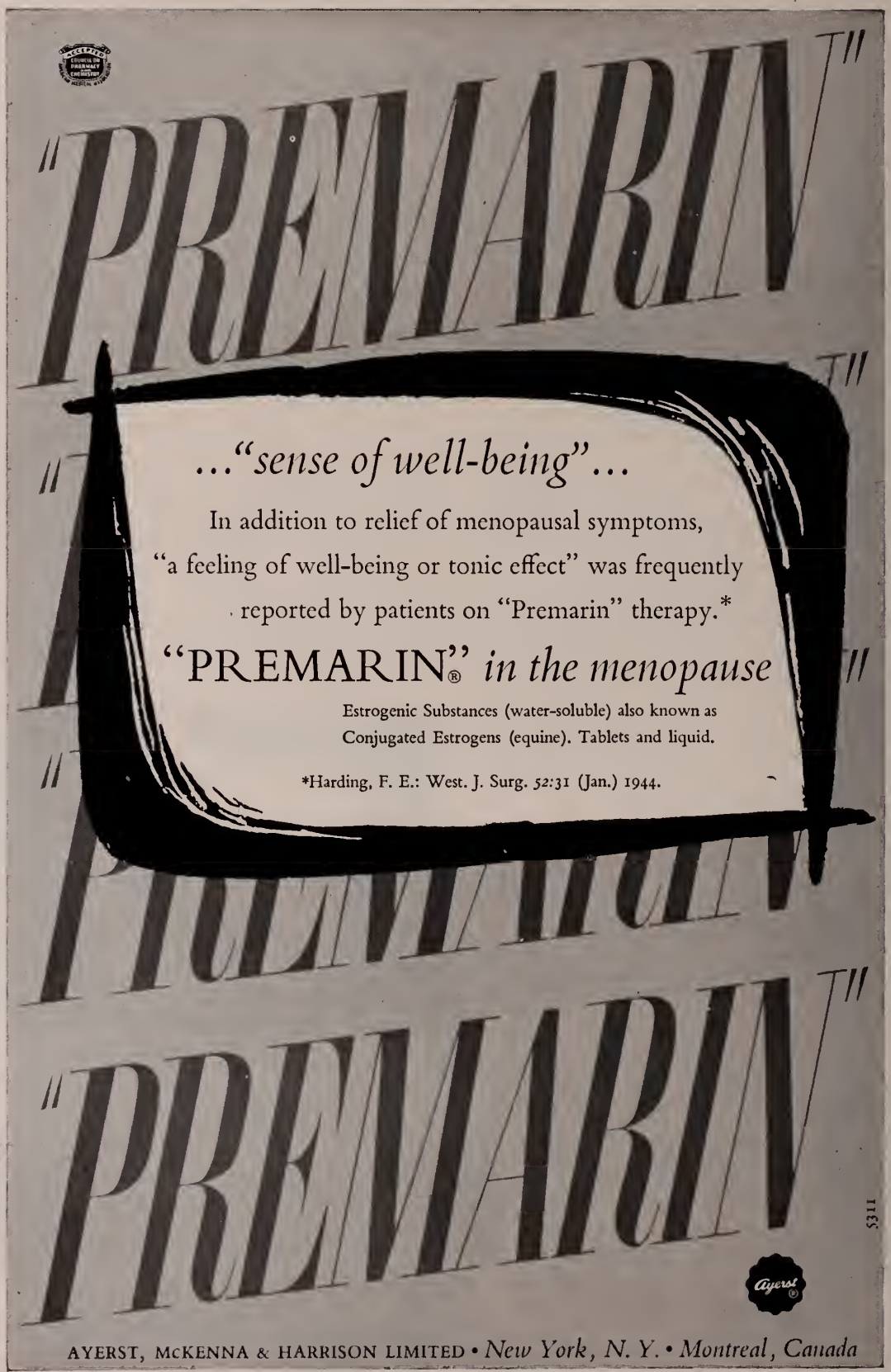


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*Harding, F. E.: West. J. Surg. 52:31 (Jan.) 1944.
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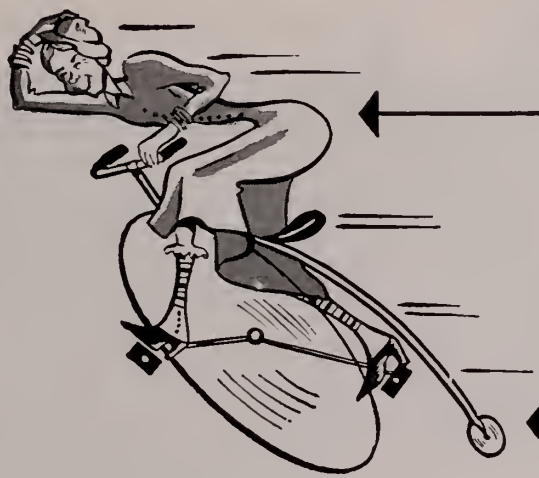
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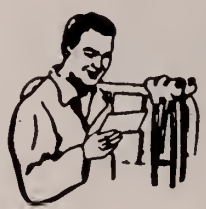
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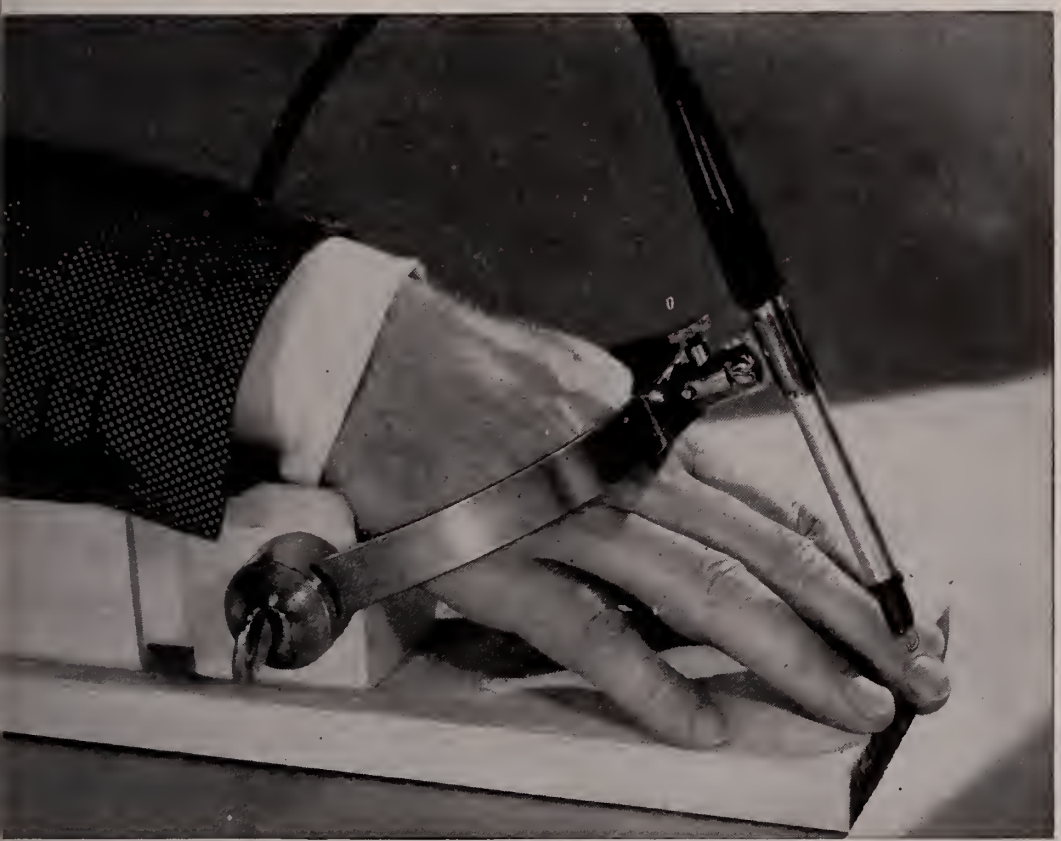
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
l Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
l Medical Districts	John D. Milton, Miami	Council Chairman	
orthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Tallahassee, Oct. 19, '53
ortheast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	St. Augustine, Oct. 20, '53
outhwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Tampa, Oct. 21, '53
outheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	West Palm Beach, Oct. 22, '53
l Specialty Societies			
ny of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
esiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
r, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
rial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
ogy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
l Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	Orlando, Dec. 5-6, '53
al. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	Hollywood, Apr. 25, '54
edic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Nov. 7-8, '53
ogists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
ric Society	Charlotte C. Maguire, Orlando	Wesley S. Nock, Coral Gables	Miami, Oct. 6, '53
logic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	Hollywood, Apr. 25, '54
ogical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
ical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
l—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 7, '53
d Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
cal Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
al Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
t Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
ital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
cal Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 22-24, '53
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
es Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
maceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
ic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	Tampa, Oct. 22-24, '53
eau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
rculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	
an's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers, Jr., Cocoa	Hollywood, Apr. 25-27, '54
an Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
n Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	Atlanta, Oct. 26-29, '53
a Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
ospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
astern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
astern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
astern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
ast Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	Mobile, Oct. 15-16, '53



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A	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	91	100%	
A	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	Terry Bird, M.D. Apalachicola	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M Watson, M. Marianna
A	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	100%	
A	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
A	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
A	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	15	11	
A	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	58	54	
A	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D Tallahassee
A	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		4	3	
A	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	100%	251
B	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Glenn O. Summerlin, M.D. 209 N. E. 2nd Ave. Gainesville	2nd Tuesday 8:00 P.M.	45	43	
B	Duval *Clay*	W. W. Rogers, M.D. 313 Professional Bldg. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	265	247	
B	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	27	100%	B-3-54 William C. Thomas, Jr.,M Gainesville
B	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	100%	
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B	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	26	25	
B	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	29	100%	
B	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	172	170	B-4-55 Thomas C. Kenaston, M.I Cocoa
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B	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	83	78	701
C	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr.,M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	178	174	
C	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	100%	
C	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M. St. Petersbu
C	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	205	203	
C	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	44	
C	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	100%	
C	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	30	100%	C-6-54 Emmett E. Martin, M.I Haines City
C	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	93	620
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
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D	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	17	16	
D	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	97	96	
D	Dade	Ralph W. Jack, M.D. 603 Dade C'wealth Bldg. Miami	Walter W. Sackett, Jr., M.D. 603 Dade C'wealth Bldg. Miami	1st Tuesday 8:30 P.M.	639	600	D-8-55 Russell B. Carson, M.I Fort Lauderd
D	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	15	13	900

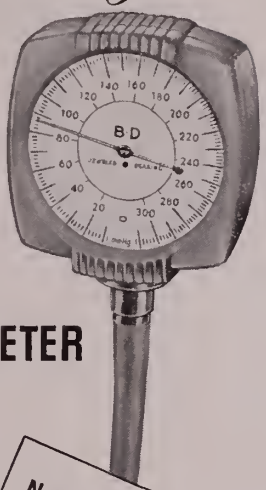
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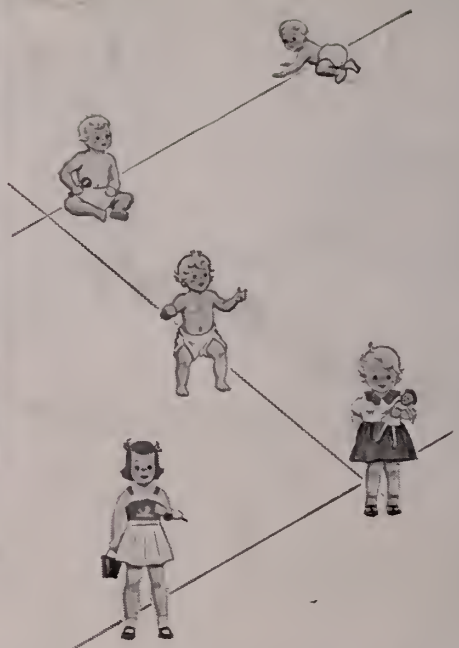
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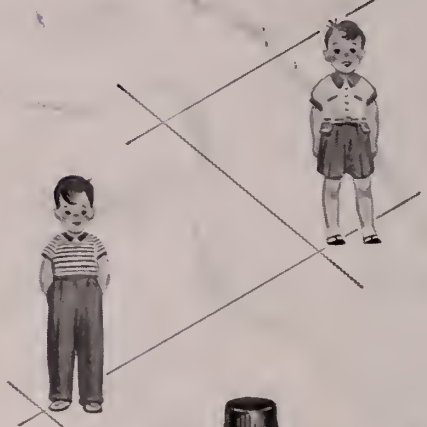
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Cholesterol, Lipoproteins and Atherosclerosis
Dale Groom

Gaucher's Disease, Thrombocytopenia and Pregnancy
William P. Logan

When and When Not to Retire
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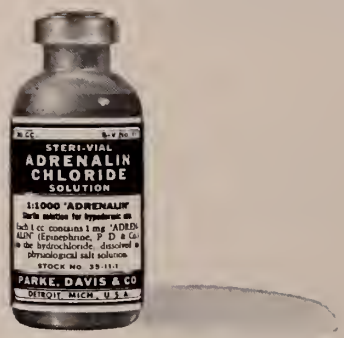
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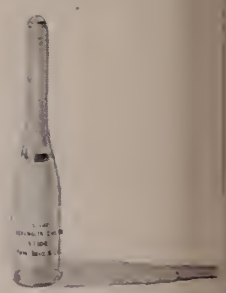
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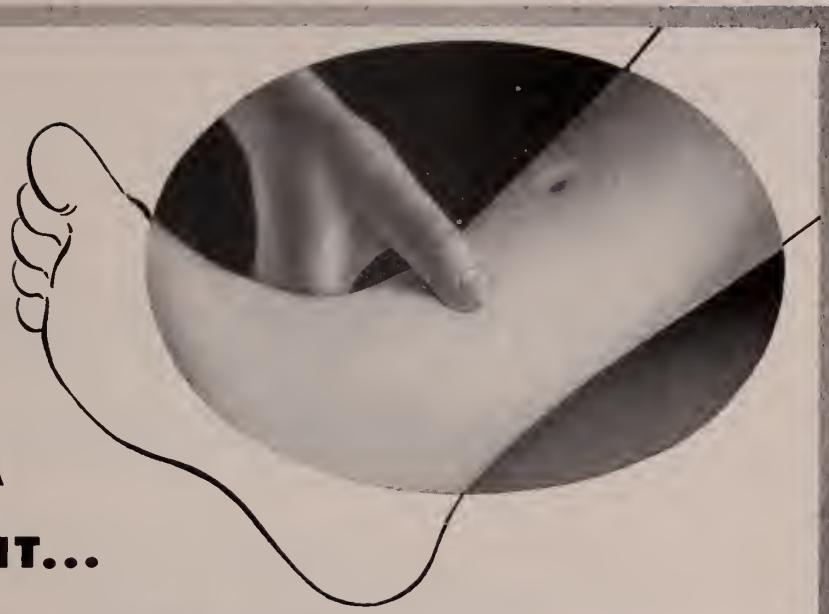
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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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1. Drabkin, D. L.: Metabolism of Hemin Chromoproteins, Physiol. Rev. *31*:345 (1951).
2. The Biosynthesis of Hemoglobin, Editorials, J.A.M.A. *150*:1223 (Nov. 22) 1952.

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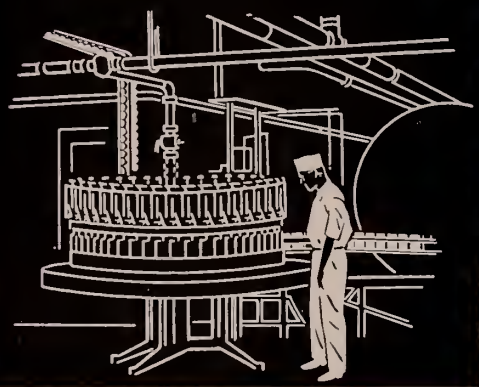
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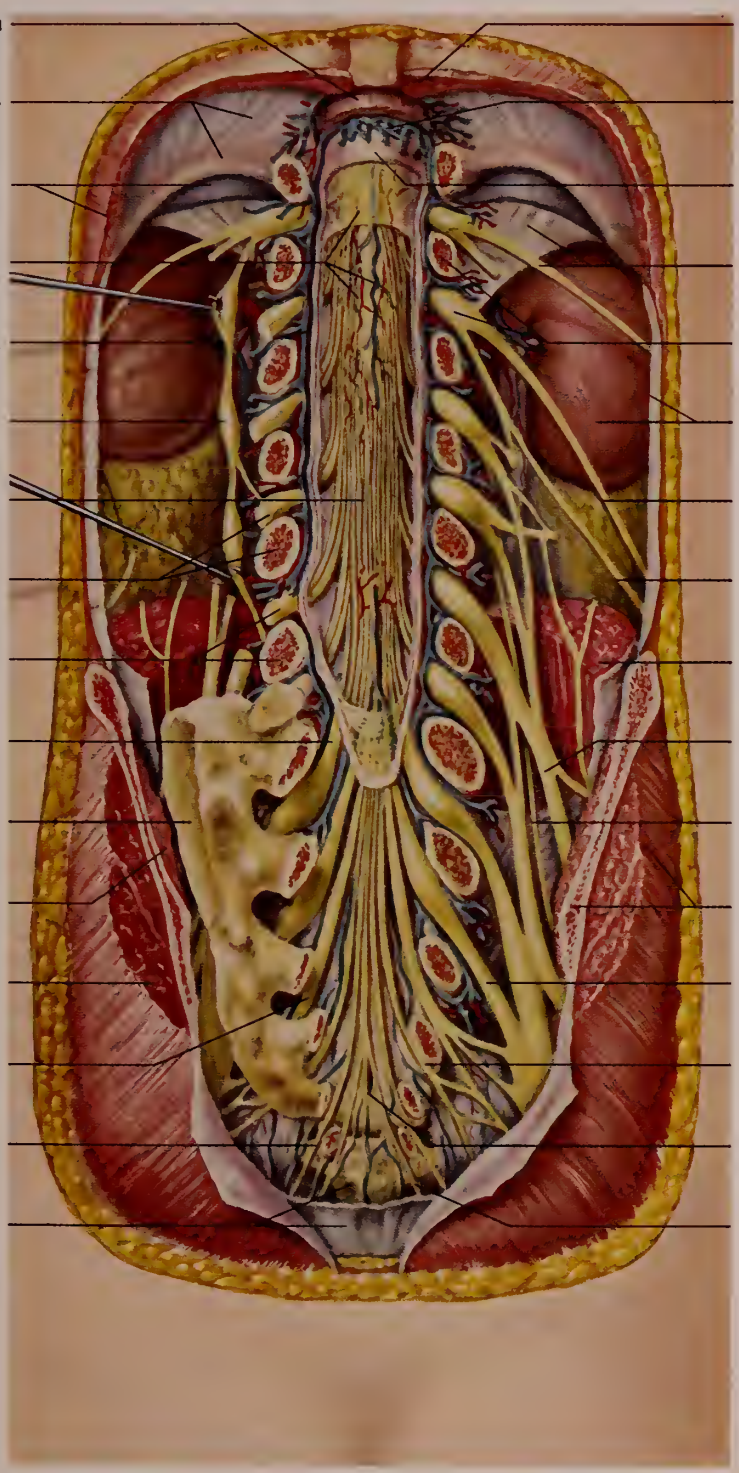
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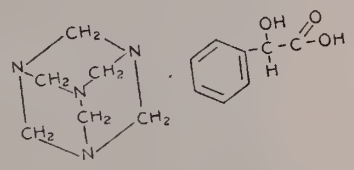
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MANDELAMINE monograph in N.N.R.

METHENAMINE MANDELATE. — Mandelamine (Nepera). — The salt obtained from the reaction of equimolecular amounts of methenamine-U.S.P. and mandelic acid-N.F. containing 48 per cent methenamine and 52 per cent mandelic acid by weight. The structural formula of methenamine mandelate may be represented as follows:



For tests and standards see Section B.

Actions and Uses.—Methenamine mandelate combines the actions of two established urinary antiseptics, methenamine and mandelic acid. The compound has the advantage that it acts to some extent as an acidifying agent, so that accessory medication to accomplish this is not ordinarily required as it is when either methenamine or mandelic acid is administered alone. However, in those infections caused by urea-splitting bacteria, preliminary acidification of the urine over a period of 24 to 36 hours prior to beginning therapy is essential to provide a urinary pH satisfactory for effective action of the compound. The combination also has the theoretic advantage that it is effective with smaller amounts of mandelic acid and may thus avoid the nausea and vomiting occasionally attributed to the use of mandelic acid alone.

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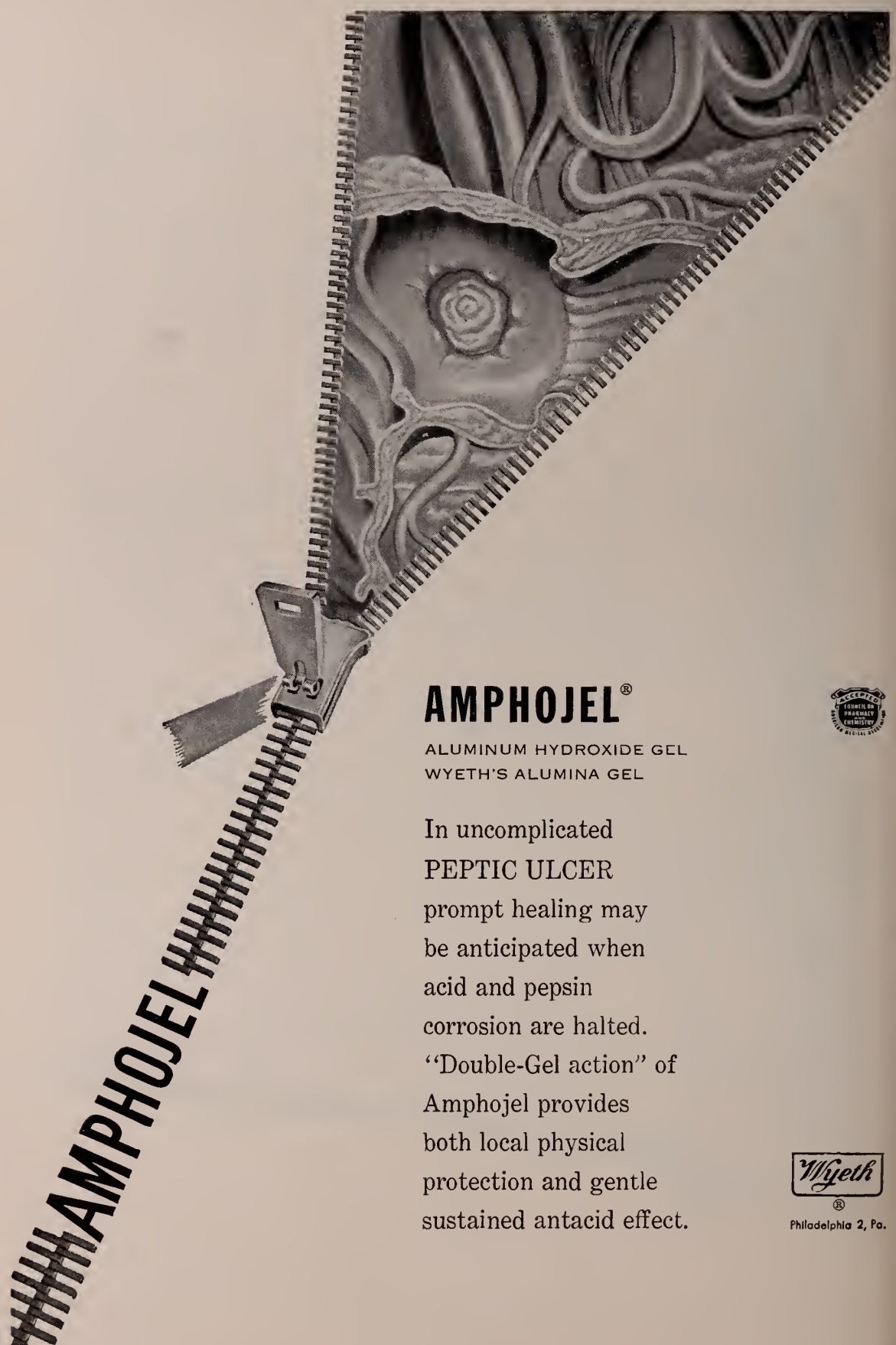
Methenamine mandelate is seldom associated with untoward effects; in therapeutically effective amounts, gastric disturbance is infrequent and other toxic manifestations are relatively rare. It is contraindicated in the presence of renal insufficiency.

Dosage.—Methenamine mandelate is administered orally. Average adult dose: 0.75 to 1.0 Gm. three times daily. For children over 5 years of age, 0.25 Gm. three times daily; infants less than 1 year of age, 0.25 Gm. twice daily.

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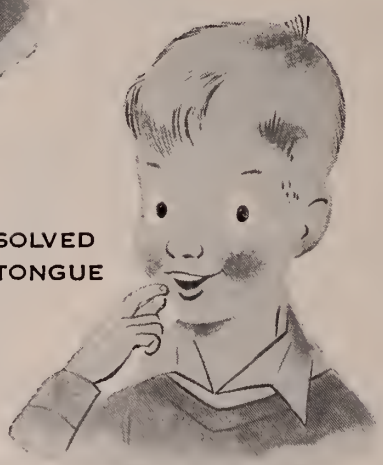


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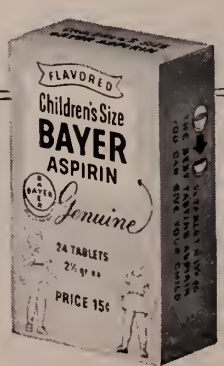


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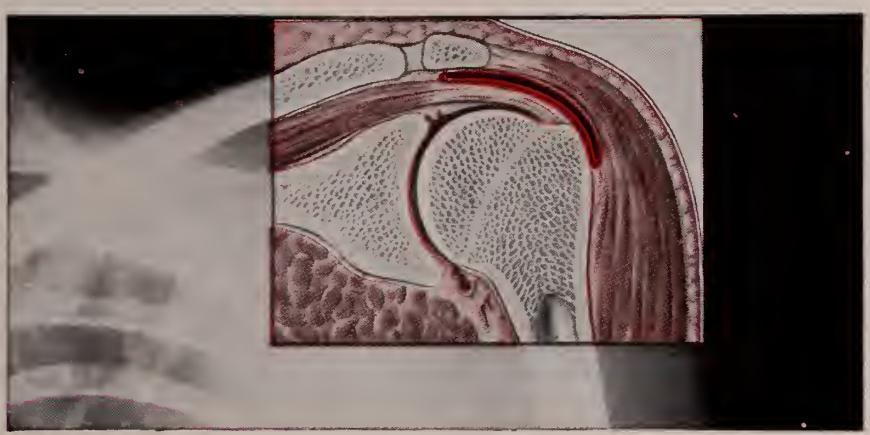
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Actions and Uses.—Nitrofurantoin, a nitrofuran derivative, exhibits a wide spectrum of antibacterial activity against both gram-positive and gram-negative micro-organisms. It is bacteriostatic and may be bactericidal to the majority of strains of Escherichia coli, Micrococcus (Staphylococcus) pyogenes albus and aureus, Streptococcus pyogenes, Aerobacter aerogenes, and Paracolobactrum species. The drug is less effective against Proteus vulgaris, Pseudomonas aeruginosa, Alcaligenes faecalis, and Corynebacterium species; many strains of these organisms may be resistant to it. However, bacterial resistance to other anti-infective agents is not usually accompanied by increase in resistance of the organisms to nitrofurantoin. The drug does not inhibit fungi or viruses.

Nitrofurantoin is useful by oral administration for the treatment of bacterial infections of the urinary tract and is indicated in pyelonephritis, pyelitis, and cystitis caused by bacteria sensitive to the drug. It is not intended to replace surgery when mechanical obstruction or stasis is present. Following oral administration, approximately 40% is excreted unchanged in the urine. The remainder is apparently catabolized by various body tissues into inactive, brownish compounds that may tint the urine. Only negligible amounts of the drug are recovered from the feces. Urinary excretion is sufficiently rapid to require administration of the drug at four to six hour intervals to maintain antibacterial concentration. The low oral dosage necessary to maintain an effective urinary concentration is not associated with detectable blood levels. The high solubility of nitrofurantoin, even in acid urine, and the low dosage required diminish the likelihood of crystalluria.

Nitrofurantoin has a low toxicity. With oral administration it occasionally produces nausea and emesis; however, these reactions may be obviated by slight reduction in dosage. An occasional case of sensitization has been noted, consisting of a diffuse erythematous maculopapular eruption of the skin. This has been readily controlled by discontinuing administration of the drug. Animal studies, using large doses administered over a prolonged period, have revealed a decrease in the maturation of spermatozoa, but this effect is reversible following discontinuance of the drug. Until more is known concerning its long-term effects, blood cell studies should be made during therapy. Frequent or prolonged treatment is not advised until the drug has received more widespread study. It is otherwise contraindicated in the presence of anuria, oliguria, or severe renal damage.

Dosage.—Nitrofurantoin is administered orally in an average total daily dosage of 5 to 8 mg. per kilogram (2.2 to 3.6 mg. per pound) of body weight. One-fourth of this amount is administered four times daily—with each meal and with food at bedtime to prevent or minimize nausea. For refractory infections such as Proteus and Pseudomonas species, total daily dosage may be increased to a maximum of 10 mg. per kilogram (4.5 mg. per pound) of body weight. If nausea is severe, the dosage may be reduced. Medication should be continued for at least three days after sterility of the urine is achieved."

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In pneumonia caused by pneumococci and staphylococci, 'Ilotycin' is very effective. Doses of 200 mg. every four hours are recommended.

Q. Is 'Ilotycin' effective in urinary tract infections?

Yes, when the causative organism is susceptible to its action and when there is a minimum of mechanical factors such as strictures, stone, and the like.

Q. How long should a streptococcus throat infection be treated with 'Ilotycin'?

The recommended minimum course for any antibiotic is five days. 'Ilotycin' completely eradicates the organisms within five days and thereby prevents recurrence of the infection.

Q. Is there any contraindication to the use of 'Ilotycin' immediately following a parenteral dose of penicillin?

No. 'Ilotycin' does not inhibit the activity of penicillin. There is probably no specific indication for using penicillin in addition to 'Ilotycin.' Experiments both in vitro and with animals have shown no evidence that 'Ilotycin' is either antagonistic to or synergistic with penicillin or the "mycins."

Q. Are coliform bacteria less sensitive to 'Ilotycin' than to other "broad-spectrum" antibiotics?

Yes. There is less possibility of monilia and fungus overgrowth in the intestinal tract with 'Ilotycin,' since the predominant organisms of the normal intestinal flora are relatively insensitive to the antibiotic action of 'Ilotycin.'

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

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The Indications for Surgery in the Treatment of Pulmonary Diseases

HAWLEY H. SEILER, M.D.
TAMPA

In no other field has surgery played such an increasingly important role during recent years as in the treatment of pulmonary diseases. Many conditions within the chest for which formerly no curative treatment was available are now curable by surgical methods. This situation has been brought about as a result of advances in diagnostic methods as well as surgical technic. In former times, the term "pneumonia" was a diagnostic wastebasket which included various and sundry diseases of the chest. Physicians now recognize many distinct disease entities within the lung, each requiring its own specific treatment. In certain instances when accurate diagnosis is impossible, exploratory thoracotomy has been recognized as a standard procedure. This operation in the hands of a competent thoracic surgeon carries an operative mortality comparable to that of exploratory laparotomy. Factors which have contributed to the remarkable safety of thoracic operations today as compared to a few short years ago include improvements in surgical technic and anesthesia, adequate blood replacement, the advent of the antibiotic drugs, and minute attention to the details of preoperative and postoperative care.

Diagnostic Methods

Today the specialist in diseases of the chest has at his command an impressive array of diagnostic procedures. The accuracy of his diagnosis to a great extent depends upon the availability and use of these tests. Despite the unquestioned value of these methods, an exact history and thorough physical examination still remain the most important part of the diagnostic study. Such factors as the patient's occupation and habits, former places of residence or travel, record of previous illnesses and surgery, symptoms apparently not related to the respiratory system, and familial disease tendencies may give important clues to the true nature of his condition. The physical examination, in addition to a study of the chest, should include a search for abnormal glandular adenopathies, various abnormalities of the skin, extremities, ear, nose and throat, and abdominal viscera.

ROENTGENOGRAPHY. — The roentgenogram, of course, remains indispensable in pulmonary diseases. Its value is well demonstrated by the fact that many pathologic conditions within the lung, without associated symptoms, are now detected by means of x-ray surveys. Lateral, oblique, and Bucky views are often important in disclosing lesions not clearly seen on the posteroanterior view, or in more accurately localizing the area of lung involved. Laminography, or planography, is of value in demonstrating cavitation. Equipment for such studies is expensive and not always available, in which case roentgenograms taken in the lordotic position are of some help, especially in revealing apical shadows which might be obscured by the clavicular and upper rib shadows. Stereoscopic roentgenograms are also useful in this connection. Diagnostic pneumoperitoneum may be employed as an aid in differentiating lesions above and below the diaphragm, and diagnostic pneumothorax is occasionally employed to determine whether or not a lesion is within the lung.

BRONCHOGRAPHY. — Refinements in the technic of bronchography now permit thorough outlining of the tracheobronchial system. Accuracy is especially important in this matter in view of

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 27, 1953.

the increased use of segmental resection in the treatment of bronchiectasis. The instillation of a radiopaque substance is also of value in demonstrating blocked bronchi from tumor or other cause.

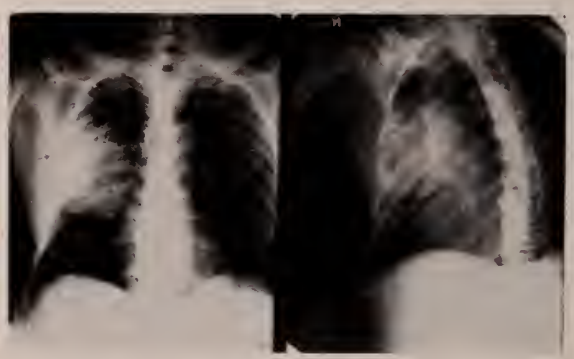


Fig. 1.—E. C. Peripheral bronchiogenic squamous cell carcinoma with invasion of ribs.

BRONCHOSCOPY. — Bronchoscopic examination and biopsy have been, and remain, an important aid in the diagnosis of pulmonary conditions. Although many bronchiogenic carcinomas are not within the range of the bronchoscope, it is often possible to obtain bronchial washings from the suspected secondary bronchus for the purpose of cytologic diagnosis. In addition, operability can often be determined at the time of bronchoscopy. Information may be gained as regards the integrity of the vocal cords, involvement of the carina, or the probability of involvement of the subcarinal nodes as evidenced by its broadening. This procedure is useful also in evaluating the degree of endobronchial disease in tuberculous patients, especially those in whom surgery is contemplated.

SPUTUM EXAMINATION. — The presence of tuberculosis, certain mycotic infections, and other nonspecific bacterial infections may be confirmed in the bacteriologic laboratory by examination of the sputum. Smear of the suspected material, culture on appropriate mediums and guinea pig inoculation in tuberculosis afford the best means of diagnosis. It is important that this material is not simply saliva, as is so often the case with sputum specimens, but actually represents secretions coughed up from the lungs. Sensitivity of the organisms to certain antibiotics can be determined following their growth on culture mediums. Examination of the sputum for malignant cells as carried out by the Papanicolaou technic offers, in some cases, a relatively early method of diagnosis. It should be emphasized, however, that a negative report is of limited significance and multiple sputum specimens should be examined.

SKIN TESTS. — A tuberculin test giving positive results in an adult is of limited value, but when the results are negative, it is of diagnostic significance in helping to rule out tuberculosis. Skin tests are now available to aid in the diagnosis of coccidioidomycosis, histoplasmosis and blastomycosis. The Casoni intradermal test, when giving positive results, is considered diagnostic of hydatid disease.



Fig. 2.—E. C. Peripheral bronchiogenic squamous cell carcinoma with invasion of ribs. Following pneumonectomy and "en bloc" excision of involved ribs and chest wall.

LYMPH NODE BIOPSY. — Accurate diagnosis may often be established by examination of involved neighboring lymph nodes. In addition to palpable axillary and supraclavicular glands, scalene node biopsy is routinely used when indicated and affords a valuable method of biopsy in some cases. Certain generalized diseases of the lymphatic system with pulmonary manifestations such as Hodgkin's disease or lymphosarcoma, may be proved by lymph gland biopsy.

EXPLORATORY THORACOTOMY. — Many lesions situated in the periphery of the lung defy diagnosis despite the use of all known tests. In cases

of this type exploratory thoracotomy is often indicated both as a diagnostic and therapeutic procedure. In certain diffuse pulmonary lesions Klassen, Anlyan, and Curtis[1] have employed a technic of pulmonary biopsy in which a wedge of lung tissue is removed for diagnosis through a small anterior intercostal incision. This procedure has carried no mortality and little morbidity in their hands. Such conditions as Boeck's sarcoid, healed miliary tuberculosis, foreign body granuloma and the like can be diagnosed by this method.

Indications for Surgery

Bronchiogenic Carcinoma. — According to Graham[2] evidence indicates that bronchiogenic carcinoma is now the most common visceral cancer in men. In several large hospitals where statistical studies have been carried out (Charity Hospital of New Orleans,[3] St. Louis City Hospital,[4] Hines Veterans Hospital[5]) the incidence of primary carcinoma of the lung has been greater than that of carcinoma of the stomach. This condition is curable when detected sufficiently early to accomplish complete eradication by surgical removal. Unfortunately, this goal is all too seldom realized. Procrastination on the part of the patient and the physician has resulted in a tragically low resectability rate. DeCamp[6] has made the interesting observation in a series of 826 cases of carcinoma of the lung that the average delay from onset of symptoms to the application of definite therapy was 8.7 months. It was possible to determine the patient and physician responsibility for delay in 707 cases, and it was found that the doctor was responsible for twice as much delay as the patient, the average delay being 5.5 months and 2.8 months respectively. With the increasing popularity of x-ray surveys, thoracic surgeons are now seeing some of these lesions earlier. The family doctor holds the key position in the matter of early detection of cancer of the lung. He often determines the next move — whether to pursue a policy of fatal watchful waiting or to continue an investigation into the true nature of the patient's disease. In the development of every cancer of the lung there is a phase during which it is still operable. This is the so-called "silent phase" described by Overholt and Schmidt,[7] during which there are no symptoms. The great majority of such lesions, however, cast a definite x-ray shadow, and this is one of the obvious great advantages of frequent chest roentgenograms, especially in the patient over the age of 35.

The treatment of bronchiogenic carcinoma, when operable, consists usually of total pneumonectomy with removal of gland-bearing mediastinal and hilar tissue. In certain selected cases[8] lobectomy has been employed. This limited procedure is usually reserved for the older age group or certain poor risk, debilitated patients and those with lowered respiratory reserve, and when the tumor appears to be well within the confines of one lobe. Palliative pneumonectomy or lobectomy is occasionally indicated, especially when secondary infection is a troublesome complication.

Bronchial adenoma is a controversial and interesting lesion usually originating in a main or subsidiary bronchus. Moersch and McDonald[9] stated that this lesion should be considered a carcinoma of a low degree of malignancy and that it possesses the ability to metastasize. Most authorities now agree with this viewpoint. Surgical extirpation of the lesion is followed by most satisfactory results although bronchoscopic removal has occasionally been employed with long periods of remission due to the slowly progressive nature of the tumor.



Fig. 3. — J. G. Rapid growth of bronchiogenic squamous cell carcinoma in a 39 year old woman to stage of inoperability in a period of less than four months.

Pulmonary Tuberculosis. — During recent years there has been a trend towards the increasing use of surgical procedures in the treatment of pulmonary tuberculosis. The emphasis has shifted away from collapse measures, such as phrenic nerve crush, thoracoplasty and extrapleural plombage, to that of resectional surgery. It is now estimated that between 35 and 50 per cent of patients with pulmonary tuberculosis, at some time during their course of treatment, will become surgical candidates. Pneumonectomy is usually reserved for the patient with a destroyed

lung or extensive bronchial stenosis. Lobectomy is employed when disease, usually in the form of cavitation, is limited to one of the five lobes or in cases of tuberculous bronchiectasis. Lower lobe tuberculosis, for example, is difficult to cure by any other means. Failure of major collapse therapy, such as thoracoplasty, often results in the necessity for subsequent pneumonectomy or lobectomy. Segmental resection has come to play an increasingly important role as a result of the knowledge that tuberculosis is, in many instances, limited to one or more of three principal segments, the apical and posterior segments of the upper lobe and the superior segment of the lower lobe. This procedure is usually reserved for residual, irreversible nodular disease, small cavitary lesions limited to one or more of these segments, or tuberculoma. Empyema with or without bronchopleural fistula is a definite indication for surgical treatment.



Fig. 4.—P. D. Far advanced pulmonary tuberculosis with destroyed right lung. Patient receiving pneumoperitoneum therapy.

Results of treatment with major surgical excision in tuberculosis have been better, by and large, than any form of therapy yet employed in this disease. This must be coupled, however, with other universally accepted forms of treatment including bed rest, sanatorium care, and the antibiotics. Proper selection of patients is of great importance, and it must be stressed that surgery is merely an adjunct in the over-all treatment of these patients.

Other surgical procedures less commonly employed at the present time include thoracoplasty, extrapleural pneumothorax, phreniclasia, and certain drainage procedures such as Monaldi or Eloesser cavity drainage.



Fig. 5.—P. D. Far advanced pulmonary tuberculosis with destroyed right lung. Roentgenogram following right pneumonectomy and concomitant thoracoplasty.

BRONCHIECTASIS.—Bronchiectasis is essentially a segmental disease and involves the bronchopulmonary segments in certain patterns. The basal segments of the lower lobes are most commonly involved although the lingula of the left upper lobe and the right middle lobe are not infrequently affected. Proper surgical treatment in this disease is entirely dependent upon accurate bronchographic mapping of the bronchial tree. If this is not done, the possibility exists that diseased segments may be left behind or that too much normal lung tissue will needlessly be removed. This is especially true in extensive cases where bilateral surgery is contemplated. Lobectomy and segmental resection are the two commonly employed surgical procedures for the eradication of bronchiectasis. Indeed, the present standardized technic of pulmonary segmental resection is a direct result of its early employment

in the treatment of bronchiectasis. As the procedure became more standardized, it was carried over to other pulmonary diseases of a segmental nature such as tuberculosis and benign tumors.



Fig. 6. — B. W. Surgical bronchiectasis involving basal segments of right lower lobe. Treated by right lower lobectomy.

Cystic Disease of the Lung. — Diffuse cystic disease of the congenital type is usually not amenable to surgical correction. Certain localized emphysematous blebs and bullae, however, should be treated surgically. These blebs and bullae often become tremendous in size with progressive compression and embarrassment to the remaining normal lung tissue on that side. In certain instances it may be possible simply to excise the bleb and repair the bronchial opening by means of suture ligature. In other cases an entire lobe will be involved, and resection of the lobe will be required. Spontaneous pneumothorax is a complication of such a condition which may require surgical treatment if repeated episodes occur.

The well defined solitary congenital cysts which include bronchial and gastroenterogenous cysts can be rather readily removed. Hydatid cysts, though rarely seen in this country, constitute a definite surgical indication.

Lung Abscess. — Chronic abscess of the lung is now being seen with more frequency than was the case several years ago. This situation is probably the result of increasing resistance on the part of the germ population to the various antibiotic and chemotherapeutic drugs. A pulmonary abscess which fails to heal in four to six weeks under satisfactory medical management should be considered chronic, and surgical methods of treatment should be instituted. Whereas drainage by thoracotomy was formerly the commonly employed procedure, it is now rather universally accepted that a clean cut surgical removal of the abscess is preferable. Primary healing can usually be expected. By this means the period of morbidity is greatly lessened. Instead of having for many weeks purulent drainage with daily dressing, the patient can usually be completely rehabilitated without complication in a matter of several weeks. The old drainage method, in addition, usually left the patient with a bronchiectatic lobe or segment. Surgical resection avoids the possible hazard of subsequent bronchiectasis. It must be remembered, too, that an occasional abscess of the lung is on the basis of a primary bronchiogenic carcinoma, and surgical removal, of course, is the only treatment in such cases.

Although lobectomy is usually required in the treatment of abscess of the lung, it is not unusual at the time of surgery to find such an abscess limited to one or two segments. In such cases segmental resection may be possible. This should not be performed, however, at the risk of possible rupture of the abscess or in the case of putrid abscess. In the treatment of any benign pulmonary disease, conservation of as much normal functioning lung tissue as possible should be practiced.



Fig. 7. — D. W. Chronic postpneumonia abscess cured by right upper lobectomy.

Benign Tumors. — Although benign tumors in the lung are comparatively uncommon, they constitute an indication for surgery when present. These lesions may cause symptoms on the basis of size or bronchial invasion. On the other hand, when a benign lesion is small, it is often impossible to differentiate it from an early carcinoma. It is safer to remove an innocuous benign tumor than to run the risk of allowing a malignant lesion to reach the stage of inoperability.

Among the benign pulmonary tumors which may be encountered are included hamartoma, chondroma, fibroma, neurofibroma, lipoma, hemangioma, and leiomyoma. Many can be re-

moved by segmental resection or wedge excision, but others require lobectomy or even pneumonectomy.

METASTATIC TUMORS. — Occasionally solitary metastatic malignant tumors of the lung are amenable to surgical removal. If the primary lesion has been adequately controlled and no evidence of other metastases exists, such a procedure is definitely justifiable. In a discussion of this subject by Seiler, Clagett, and McDonald,[10] experience indicated that in some instances survival for many years might be expected to follow such a procedure while at other times the degree of palliation afforded made the attempt worth while. Best results were obtained in resection of metastatic fibrosarcoma and hypernephroma.



Fig. 8. — R. B. Congenital cyst, right lower lobe, in a 4 year old boy. Treated by enucleation excision of cyst.

MYCOTIC INFECTIONS. — Excisional pulmonary surgery is employed in certain fungus diseases when sufficiently localized. Melick[11] has assembled a group of 109 cases in which pulmonary coccidioidomycosis was treated surgically. Pneumonectomy, lobectomy, segmental resection, and local excision were all employed in this group of cases. Other mycotic diseases which have been treated by surgical means when in the localized form include histoplasmosis,[12, 13] blastomycosis,[14] aspergillosis,[15, 16] and cryptococcosis.[17]

ARTERIOVENOUS FISTULA. — Pulmonary arteriovenous fistula is being seen with increased frequency. This condition may be encountered when far advanced with disabling symptoms or may be discovered on routine x-ray survey in the asymptomatic stage. Because of its progressive nature with resulting cardiopulmonary disability, surgical treatment is indicated when feasible. The well known tendency of this lesion toward multiplicity dictates extreme conservatism in its surgical treatment. Lobectomy is often required, but segmental resection will suffice in some instances. Obliteration by means of ligation of the vascular supply and local excision of the aneurysmal sac has occasionally been possible.[18]



Fig. 9.—H. J. Solitary pulmonary metastasis from carcinoma of colon; associated spontaneous pneumothorax.

CHRONIC GRANULOMAS AND MIDDLE LOBE SYNDROME. — Occasional nonspecific granulomatous lesions are encountered in the lung whose etiology is obscure. At times it is possible to demonstrate such granulomas to be on the basis of silicosis[19] or some other irritant. Often, however, it is not possible to determine the cause. These tumors may grow to large size and are usually mistaken for carcinoma until proved otherwise by pathologic examination. Graham, Burford, and Mayer[20] described a form of nonspecific pneumonitis and atelectasis characteristically seen in the right middle lobe. This condition is apparently on the basis of bronchial obstruction and has been subsequently recognized and described by other writers. Here again it is difficult to rule out a malignant lesion preoperatively, and surgical removal of the involved middle lobe is curative when carcinoma is not present.

Indeterminate Lesions. — Overholt[21] repeatedly emphasized the need for exploration in silent or indeterminate disease of the lung. In peripherally situated lesions it is a common experience that all diagnostic tests will give negative results. Delay in treating such lesions is not justified, especially in men over the age of 35. In the Overholt Thoracic Clinic, 162 cases of undiagnosed survey lesions were explored of which 58 proved to be neoplasms, 39 of these being malignant. Johnson, Clagett, and Good,[22] in a series of 53 cases of indeterminate pulmonary mass lesions, found 74 per cent to be malignant. When doubt exists as to the nature of an abnormal roentgen density, exploratory thoracotomy should be performed in most instances and adequate tissue obtained for diagnosis. Following biopsy of such a lesion by means of local excision or segmental resection, more extensive surgery can be performed if indicated. It is by this means only that surgeons may hope to improve the mortality figures in conditions such as bronchiogenic carcinoma.



Fig. 10. — H. J. Solitary pulmonary metastasis from carcinoma of colon; associated spontaneous pneumothorax. Following decortication and segmental resection, posterior and apical segments, right upper lobe.

Summary

Technical advances in surgery of the lung plus increased diagnostic acumen during the past decade have made many pulmonary lesions amenable to surgery which formerly were treated symptomatically or by medical methods alone. In the treatment of cancer, the most important factor is time. This is especially true in the case of bronchiogenic carcinoma when such a lesion may remain practically asymptomatic until inoperable. Although accurate diagnosis of pulmonary lesions is now often possible, there still remains a group of lesions which defy diagnosis. Continued observation of such lesions will often prove disastrous and may reflect discredit upon the physician for unwarranted procrastination.

Pulmonary surgery has proved of tremendous value in shortening the course of and bringing relief to sufferers from certain chronic diseases such as pulmonary tuberculosis, bronchiectasis, abscess of the lung and some of the mycotic infections. It has proved of value in such formerly hopeless conditions as metastatic malignant disease.

Other pulmonary conditions in which surgery is indicated include bronchiogenic and gastroenterogenous cysts, emphysematous blebs and bullae, benign tumors, arteriovenous fistulas, chronic granulomas, and certain indeterminate lesions.

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Discussion

DR. DEWITT C. DAUGHTRY, Miami: Dr. Seiler has certainly given an excellent presentation covering a broad field. A few points that he did not mention and a few that should be re-emphasized will be presented. One that he mentioned, but not in quite the same manner in which I am going to mention it, is the vanishing lung. Sometimes one encounters a bleb which has become so large that it completely compresses the lung and may be confused with spontaneous pneumothorax. By a simple procedure this bleb, bulla or lobe can be removed, thereby restoring the function of the lung. Often only a small area of the lung or just an isolated bleb does this damage. Spontaneous pneumothorax of considerable extent should be treated by placing a decompressing catheter in the thorax, thus greatly reducing the period of illness. My associate and I recently reviewed some 60 cases in which this type of treatment has been carried out, and there were 20 cases as controls treated by other groups in the same hospitals. In our cases the patients were well in five days as compared to 28 days in the conservatively treated group. The economic advantage is obvious, not to mention the much higher incidence of complications in the bed rest or no treatment group.

A procedure of great value is tracheotomy in patients who are unable to bring up their own secretions. They may have retained secretions and die, not of a head injury, stroke or polio but from so-called pneumonia, which is just a matter of not cleaning out secretions from the tracheobronchial tree. Sometimes this can be accomplished by catheter suction repeated every day. This is a very important consideration in tetanus.

Surgery of the trachea and bronchi should receive a little attention. Not infrequently injuries occur in which the trachea or one stem bronchus may be torn or severed. Immediately it becomes necessary, particularly if the injury is in the thorax, to institute treatment to keep the patient from dying of a pneumothorax or respiratory insufficiency. We have encountered 3 such cases recently, 1 in which the trachea was severed except for 1 cm. of the membranous portion. Another type of condition in which tracheal or bronchial surgery is necessary is a small or sometimes even a large tumor. If the tumor is benign, a bronchotomy may be performed, removing the tumor and a small amount of tissue about it. As for a malignant tumor, some kind of plastic procedure may be necessary, such as the use of tantulum mesh or some type of plastic material to bridge the defect due to removal of a portion of the trachea.

Some diseases should receive a little attention which more or less secondarily involve the lung. One of them is metastatic disease, which has been mentioned. Another is tracheoesophageal fistula, which will be discussed later, but I will say that this condition, if not corrected within the first few days of life, will cause the patient to die a respiratory death. Respiratory conditions may be produced secondarily by subdiaphragmatic disease. A diaphragmatic hernia in the newborn in which all of the intestinal contents may be in the chest will usually produce a respiratory type of death unless it is corrected. There are other hernias which are not particularly important. Congenital vascular rings may produce acute symptoms in the form of respiratory distress. A patient of mine came in with acute respiratory distress in which there was a double aortic arch, and it had almost occluded the trachea.

I should like to stress one thing about lipiodol bronchograms in pulmonary disease. I believe that they are absolutely contraindicated if there is a suspicion of carcinoma of the lung. Often in our cases in which a bronchogram has been made, the lipiodol persists around the lesion that is being observed, and it stays there so long that the lesion really may not have accurate observation for a period of months or until inoperable. We see many inoperable carcinomas from that one procedure. I should like to say also that a carcinoma of the lung may be present with a roentgenogram giving negative evidence. Six such cases have come under our observation in about three years. When I said roentgenogram, I meant the conventional posteroanterior view which usually is taken; so often a lateral view is neglected. If a lateral view is taken, many of these lesions hidden behind the heart may be demonstrated. In 3 of our cases the carcinoma was demonstrated on a roentgenogram taken in the lateral position, but could not be seen in a posteroanterior view. Three additional carcinomas were demonstrated by bronchoscopy with a roentgenogram giving entirely negative evidence.

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Cholesterol, Lipoproteins and Atherosclerosis: Present Concepts

Dale Groom, M.D.
MIAMI

It is a well documented fact that atherosclerosis is the leading cause of death in our American civilization today. Indirectly, this fact pays a real tribute to the medical progress of the last 150 years, which has given us the longest life expectancy of any people in history, for now a greater proportion of our population lives on into middle and later life — the "atherogenic years." To some extent it is also a tribute to better diagnostic acumen, aided by such instruments as the electrocardiogram. But growing older and wiser is doubtless not alone responsible. Evidence is accumulating which strongly suggests that atherosclerosis is not an inevitable consequence of age, and that it may be directly related to abnormalities of fat metabolism and to the inordinately high fat content of the average American diet. Atherosclerosis is, in fact, being viewed as a disease rather than an inevitable degeneration, and as such, potentially amenable to treatment.

The atherosclerotic lesion has long been recognized as the basic pathology in the vast majority of cardiac and cerebral deaths. It has been the subject of investigations for more than a century. Prior to the last decade, however, these laboratory investigations were predominantly descriptive in nature — the pathologists' descriptions of the lesions as found at autopsy. During the last 10 or 15 years there has been an increasing flow of contributions from physicists, statisticians, biochemists and physiologists, along with the clinicians. It is the purpose of this presentation to summarize the findings of some of these recent experimental approaches to the nature and causes of atherosclerosis, particularly in the light of what might be transferable from the laboratory to the patient.

To the pathologist the terms atherosclerosis and arteriosclerosis are not synonymous. Atherosclerosis is that type of arteriosclerosis which characteristically produces fatty infiltration of the intima of arteries with resultant intimal degeneration, fibrous proliferation, and encroachment on the arterial lumen leading ultimately to complete occlusion by thrombosis. Arteriosclerosis is a more general term including degenerative changes in any of the arterial layers; it is commonly used to denote the medial sclerosis by collagen and fibrous changes which produces the thickened, hardened, tortuous "pipe stem" artery, the lumen of which may be entirely unobstructed. Virtually all the recent studies have been directed toward the former, the atherosclerotic lesion, which destroys organs by depriving them of their blood supply.

The idea that some factors other than age might be involved in the development of atherosclerosis is not new. More than a century ago cholesterol was identified as the chief substance present in atherosclerotic lesions, and it has been almost 50 years since similar lesions were produced experimentally in animals by cholesterol feeding. There have followed the innumerable clinical studies showing a statistically higher incidence of atherosclerosis among obese persons, and in patients having certain diseases characterized by a tendency to elevation of blood cholesterol levels, namely, hypothyroidism, diabetes mellitus, xanthomatosis, and hereditary hypercholesterolemia. All of these observations have been confirmed repeatedly. In addition, there have been some interesting reports suggesting that the converse might also be true: that those who subsist on diets low in fat content (the Chinese, the Okinawans, populations subjected to famine such as that prevailing in wartime Europe, and patients dying of protracted wasting diseases) show a remarkably low incidence of atherosclerosis at postmortem examination. Obviously, age alone cannot account for such findings. Nor can it account for the fact that the disease is often present in its most severe form in hearts of patients under 45 years of age, while it

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may be almost absent in hearts of patients aged 70 years and beyond. Nor, of course, can the aging theory explain the great predisposition of the male toward coronary atherosclerosis.

Cholesterol itself is a fatty monatomical alcohol having the chemical formula $C_{27}H_{45}OH$. Normally it is present in all cells of the body, possibly as an essential constituent of protoplasm, and serves as one of the basic building blocks in the body's synthesis of certain hormones, particularly the steroids of the adrenal cortex. It is ingested in food (the exogenous cholesterol) and is also synthesized in the liver (endogenous) to the extent that the body is able to maintain an adequate blood level of cholesterol on a cholesterol-free diet. Principal exogenous sources of supply are animal fats, oils, whole milk and egg yolks, and to some extent the organ meats such as liver, brains and sweetbreads. The level of cholesterol in the blood varies widely in different persons and in the same person at different times, and is known to be affected by diet, pregnancy, age, and the presence of certain metabolic, hepatic and renal diseases. Unfortunately, cholesterol from the blood can be deposited beneath the intima of blood vessels. Whether this position is accomplished primarily by phagocytosis, chemical irritation, crystallization, or mechanical filtration is not certain. At any rate, it appears reasonable to assume that the deposition of cholesterol and other lipids, if not the actual cause, is at least the method of production of the atheromatous lesion.

Animal Experiments

The experimental production of atherosclerosis necessarily has been confined to laboratory animals. Rabbits, chickens, guinea pigs, mice and dogs have all been found to be susceptible in varying degrees peculiar to their species. While one may question the significance of results obtained by feeding an herbivorous animal such as the rabbit large quantities of animal fats, or the applicability of any experimental animal results to human physiology, these experiments are providing some interesting and surprisingly uniform clues.

Animal investigations have yielded a massive amount of data. Not all the reports are in agreement on some findings, and there are numerous others which await further verification, but it now has been reasonably well established that:

1. In susceptible animals the prolonged feeding of a high cholesterol high fat diet is capable of producing elevation of blood cholesterol levels and atheromatous lesions.

2. These experimentally produced lesions are similar histologically and chemically to the lesions of human atherosclerosis.

3. The atherogenic effect of cholesterol and fat feeding is enhanced by concurrent depression of thyroid activity, as with thiouracil.

4. In thyroid deficient animals the concurrent administration of thyroid decreases the incidence and severity of experimental atherosclerosis.

There is also considerable indirect evidence suggesting that these animal lesions produced experimentally may be at least partially reversible;[1, 2] for example, some animals which were taken off the high cholesterol and fat diet at a relatively early stage showed great improvement in their appearance and also less atherosclerosis at later postmortem examination than did others examined at that stage. Apparently the lesions become irreversible at advanced stages of development.

So-called "lipotrophic substances" such as choline, methionine and inositol have been tried repeatedly in attempts to deter the development of experimental atherosclerosis, but have been generally disappointing. Other compounds have been employed for the same purpose with somewhat less conclusive results, notably, lipocaic, aluminum hydroxide gel, "intravenous detergents" such as "Tween 80," and the emulsifying agent lecithin. Certainly the evidence thus far in animal experiments, as well as in clinical trials, has failed to justify the prevailing widespread use of lipotrophic substances in human atherosclerosis.

Studies in Man

At present the most promising avenue of approach to the problem of human atherosclerosis is clearly that of fat metabolism. Recent studies have dealt almost exclusively with statistical correlations of presence or absence of the disease with amounts of the various fatty components of blood, diet, or body tissues. The question in man is not what factors can be made to produce atherosclerosis, but what factors do produce the disease in some persons and not in others — or, perhaps, what factors serve to protect some against the disease and are lacking in those showing extensive atherosclerosis. Because of man's relatively long life span the experiment has just begun.

The hazards of such an approach are obvious. Since many years, and perhaps many factors, are required for the development of demonstrable atherosclerosis, and the factors under study are known to vary considerably from time to time, data on diet or blood levels or habits at any one period of life are not necessarily representative of the total situation. Furthermore, no adequate group of normal controls is available. With atherosclerosis which will ultimately be fatal now developing in a large proportion of the population, there still is no reliable means of detecting the disease until some usually catastrophic event such as a coronary thrombosis occurs. Even then the presence of a myocardial or cerebral infarction does not reveal the extent of the patient's generalized arterial involvement; it indicates only that a segment of a critically involved artery for which there is inadequate collateral circulation has reached the end stage of occlusion. And, presumably, there are factors other than atherosclerosis involved in thrombotic occlusion, for thrombosis has been known to occur in histologically normal arteries. Finally, there is the ever present human factor itself which can alter the diet or color the history or obscure symptoms.

Nevertheless, the numerous studies in man have indicated repeatedly that:

1. Blood cholesterol levels are normally low in the early years of life, then tend to rise rapidly during the third and fourth decades on up to about the sixth decade, after which a slow decline is the rule. Most of these observations, however, are on different persons in different age groups rather than on the same persons followed through the years.

2. There is a definite, though not complete, correlation between the presence of atherosclerosis as determined by clinical, electrocardiographic, or autopsy findings and the presence of abnormally high blood cholesterol levels.

3. Blood levels of lipids and cholesterol are by no means a reliable index of present or impending atherosclerosis since the disease develops in a considerable number of subjects with consistently low levels while in some with high levels it does not develop.

4. In patients with abnormally low thyroid activity there is an increased incidence of atherosclerosis, and also a characteristic elevation of blood cholesterol values which can be reduced by thyroid medication.

In addition, evidence is accumulating which indicates that:

1. The amounts of cholesterol and lipids in the blood of most subjects will decrease upon changing from the average American diet to one sufficiently low in these substances. Usually several weeks are required, and the restriction must include fats, both animal and vegetable, as well as cholesterol intake. Some of the earlier work reporting negligible reduction by dietary control was carried out without sufficient restriction of total fat.

2. Postprandial elevations of blood lipids tend to be higher and more prolonged in atherosclerotic patients than in presumably normal subjects. This observation is based largely on "cholesterol tolerance" and similar tests, and on studies with the dark field microscope by Moreton[3] showing showers of chylomicrons visible in the blood following fatty meals.

Interest has also been aroused in the quantitative relationship of cholesterol to phospholipids in the blood. A "cholesterol/phospholipid ratio" has been proposed as of greater value than determination of either substance alone. It is suggested that in hypothyroidism cholesterol tends to increase while phospholipids do not, that in patients with coronary disease the phospholipids fail to increase with age as does the cholesterol, and that the greater the difference between the two levels the higher the incidence of atherosclerosis. In pregnancy and menstruation, however, the two are thought to rise together. Some investigators have speculated that the phospholipids may act as a protective factor, modifying or preventing atherogenesis. The evidence, however, is not conclusive and the possibility of statistical artefacts considerable, for all these substances are themselves closely related to lipoproteins.

Gofman's Contribution

Prior to 1949 virtually all studies correlating blood cholesterol with atherosclerosis were based on the familiar quantitative determinations of these compounds by chemical analytic methods. Since they are present in the blood not in pure molecular form but combined with proteins and lipids into large molecules having their own unique characteristics, it appeared plausible that a study of the characteristics of the native molecules might uncover information more relevant than answers in terms only of total amounts of

cholesterol and esters. It is analogous to identifying the individual types and properties of bacteria present in a sample as against determining only the total number of bacteria. On the hypothesis that "the physiochemical nature of the native blood lipids might be more significant than the analytic lipid levels themselves," Gofman and his colleagues at the University of California undertook their ultracentrifugal studies.[4-6]

The ultracentrifuge has long been familiar to the physicist, but has found only a few applications in medical research, chiefly in virus studies. In its present form it is a somewhat elaborate but well standardized instrument which is capable of recording graphically the relative amounts of molecules of different sizes and densities in a small sample by means of their behavior under extreme gravitational force. At 200,000 G large molecules can be made to migrate in an orderly sequence over a period of time, arranging themselves in a manner determined by certain physical properties which differentiate them. Migration in a centripetal direction is flotation, measured in Svedburg units, or simply Sf units. Hence these native blood molecules containing the cholesterol and other lipids, in combination with proteins, and having molecular weights generally well above a million, are designated as lipoproteins of specific Sf values.

In essence, Gofman's contribution has been the finding that atherogenesis is associated with the presence of a particular group of lipoprotein molecules in the blood of man, namely, those molecules having flotation rates of 10-100 Svedburg units, and particularly those of the Sf 12-20 and 35-100 classes. Originally this was a purely empiric observation stemming from studies on experimental atherosclerosis in rabbits in which it was noted that the incidence and severity of arterial lesions paralleled remarkably the blood concentration of certain large molecules as measured by the ultracentrifuge technic. Then began the collection of data on several thousand human subjects, with and without evidence of disease, on which Gofman's conclusions are based.

Of special interest in the light of the previously described cholesterol and lipid studies is the relationship of these substances to the atherogenic molecules. Generally, elevation of one is accompanied by elevation of the other. The Sf 12-100 fraction, however, contains only about 10 per cent of the total blood cholesterol, the remainder being carried in other lipoproteins which show no significant correlation with atherosclerosis. In fact, blood samples from some atherosclerotic subjects show normal or low cholesterol levels and elevated Sf 12-100 fractions, while some normal subjects show the reverse. This variation would explain some of the discrepancies in the earlier cholesterol correlations.

Photographs recently have been made of lipoprotein molecules by means of the electron microscope, as reported by Prendergast,[7] and their size calculated to be on the order of 25 mu. With their known density, this would correspond closely to the molecular weight of 3 million estimated from ultracentrifuge measurements.

Like total cholesterol, amounts of Sf 12-100 molecules are normally lowest in infancy, highest in middle life, and somewhat decreased in blood samples from elderly subjects. They are similarly altered in the presence of diabetes mellitus, xanthomatosis, hepatic impairment and untreated hypothyroidism (in which there is the highest incidence of elevated levels.) Males tend to show higher levels than do females. The incidence of elevated levels in single samples from a large group of patients with proved myocardial infarction was over 90 per cent. In random groups of "normals" the incidence was approximately the same as that of atherosclerosis in autopsy studies.

Abundant data are available on the effects of diet. As a rule diets high in fat content produce an increase in Sf 12-100 molecules while those restricting total fats and cholesterol, on the order of 50 Gm. and 100 mg. respectively per day, result in a decrease. About a month is usually required for the full changes to take place.

An interesting observation reported from the ultracentrifuge work is the remarkable effect of heparin[8] on lipoproteins. When 20-100 mg. of heparin is injected intravenously, a consistent and dramatic reduction is said to occur in the levels of Sf 12-100 molecules which far outlasts the known action of heparin on the blood clotting mechanism. A similar effect has been noted by Block, Barker and Mann[9] on translucense of blood plasma during alimentary hyperlipemia, with male atherosclerotic subjects showing less clearing of the plasma following heparin administration. It is postulated by the Gofman group that a progression of lipoproteins from molecules of high Sf values to lower ranges occurs normally in fat metabolism, and that heparin may in some manner alter this progression toward the Sf 3-8 class which shows a proportionate increase. Ad-

ministration of heparin twice a week has been found to be capable of maintaining prolonged diminution in the Sf 12-100 fraction with at least subjective improvement in some patients suffering from angina pectoris. Certainly it would appear that if any means of altering the progression of atherosclerosis is to be of real therapeutic value, it must necessarily be employed long before the stage of irreversible damage to the vital organs is reached. Hence the urgent need for earlier detection of atherosclerosis, which may ultimately prove to be the major contribution of the ultracentrifuge studies.

Conclusion

It is of course not contended that cholesterol, lipoproteins, or lipids of any sort are the sole cause of atherosclerosis. Mechanical factors, vasoconstrictors and individual differences in the arteries themselves doubtless all play a role. Recent studies relating to fat metabolism, however, appear to offer the most promise thus far of predicting, and perhaps some day of treating, atherosclerosis in man.

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Discussion

Dr. Virgil Moon, Miami (by invitation): This discussion of the modern concept of the genesis of atherosclerosis has been so complete that it leaves little for the discussant except to underscore by way of emphasis certain features that Dr. Groom has brought out. Perhaps the first thing to be underscored is the conception that atherosclerosis is a disease, not simply a degenerative process which is inherent in us as we advance in decades. Diseases are amenable to prevention and to treatment. Sometimes they are amenable to cure. That conception provides a hopeful attitude toward the problem which formerly was regarded as rather hopeless. Perhaps the situation is not as hopeless as it was formerly regarded.

This disease is associated with several conditions, principally disturbances of lipid and of cholesterol metabolism. The conditions in which there are such disturbances are those in which atherosclerosis is prone to develop, those in which there is a high blood level of cholesterol and those in which thyroid activity is low. In addition to these contributory factors, another such factor is that high blood pressure in itself will cause the development of atherosclerosis in arteries. For example, when the pulmonary arterial blood pressure is abnormally high, atherosclerotic patches develop in the pulmonary arteries.

This disease also is associated with dietary factors. As Dr. Groom mentioned, in areas where famine — war famine — has been prevalent during a long period of time — a period of time measured in years — and also among those whose diet is naturally restricted in fats, there is decreased occurrence of atherosclerosis in the population. This is attributed to the abnormally low fat content of the diet.

The work of Gofman is certainly most stimulating. The fact that cholesterol and other lipids combine with proteins in large molecules which are found in higher concentration in atherosclerotic than in so-called normal persons is significant. It suggests that perhaps there is a factor there which could be recognized clinically before atherosclerosis has produced irreversible changes.

Naturally the ultracentrifuge is entirely too elaborate and expensive a piece of equipment to be applied clinically in the study of cases, but such changes as were demonstrated by the ultracentrifuge may also be demonstrable by other means. I have in mind a much less complicated one than the ultracentrifuge, that of iontophoresis or electrophoresis. The quantity of particles of varying size in the plasma can be shown by electrophoresis. While the necessary apparatus is not one which the clinician can use in his office, it is nevertheless one which could be used provided the molecules described by Gofman are definitely associated with the development of atherosclerosis and provided the electrophoretic pattern will detect them. I believe it will, although I have seen no report of its use for that purpose. Have you, Dr. Groom?

Dr. Groom: Yes, it is being tried to some extent.

Dr. Moon: I think analysis by electrophoresis is a promising lead to be followed up. The most hopeful feature in this situation combines two phases. One is the fact that experimental atherosclerosis is reversible; if detected and the cause is removed, the arteries return to a normal state. The disease is interrupted. The other is the fact that some agents may change the process itself basically, as, for example, heparin. It is not implied that heparin itself might be useful in the treatment or prevention of atherosclerosis. It is implied, however, that if heparin will produce those effects, other drugs may be found which will be more effective.

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Adult Gaucher's Disease Complicated by Thrombocytopenia and Pregnancy

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Gaucher's disease comes to the physician's attention at some time or other. Usually, because of its rarity, it is encountered only in the course of studying the various lipoid disorders. The case reported here, which was complicated by thrombocytopenia and pregnancy, presents an opportunity to review this disease, particularly in the light of present conceptions of splenic function.

Gaucher first described this entity in 1882, considering it an epithelioma of the spleen. Later, this condition was recognized to be the result of a familial disorder of metabolism, in which there is an abnormal storage or retention of large amounts of the cerebroside kerasin within the cells of the reticuloendothelial system. While multiple cases often occur in families among siblings and cousins, rarely is the disease observed spreading from one generation to another.[1] It usually occurs in the white race with the highest incidence among the Jews, and the sex incidence seems to be about equal, although some report finding it more often in females.

The presence of large pathognomonic Gaucher cells forms the fundamental pathologic finding.[2] While these cells occur throughout the reticuloendothelial system, they are most numerous in the spleen, but are also present in the liver, bone marrow and occasionally the lymph nodes. Only rarely have they been seen in the circulating blood. They are considered to be of reticuloendothelial origin. Their most characteristic feature, however, is the relatively clear cytoplasm which contains fine fibrils giving it a parchment paper appearance. Because of this, they are sometimes called "foam cells." This distinctive appearance is caused by the accumulation of kerasin within the cell producing a large cell (20 to 40 microns or more in diameter) with one, though sometimes multiple, small eccentric nuclei.

In contrast to the acute form occurring in infants, the disease in adults pursues a chronic course.[3] While it actually begins in childhood or early adult life, the clinical picture may not manifest itself for many years. The first indication of the disease is often the presence of an enlarged spleen noted frequently during a routine physical examination. For many years thereafter few, if any, symptoms are present. Eventually, the spleen will enlarge sufficiently to produce a dragging sensation or distress in the left side of the abdomen. Usually, about this time, a normocytic anemia will be present. Epistaxis, bleeding about the gums, petechiae and ecchymosis will frequently occur, the results of a thrombocytopenia. Other cytopenias, even to a complete pancytopenia may be present. Prior to the use of antibiotics, death was often the result of intercurrent infection; however, Gaucher's disease, in itself, is rarely fatal, as indicated by the increase in the diagnosis in elderly persons.[4]

Other less characteristic clinical findings may be encountered.[4,5] Pingueculae are usually seen in older patients. These are yellowish wedge-shaped thickenings of the subconjunctival tissue, located on both sides of the cornea. There may also be a hemochromatosis-like pigmentation of the exposed skin surfaces, occurring in about 50 per cent of these cases. Jaundice is rarely, if ever, present, and liver function tests are usually normal even though the liver is frequently enlarged. Biochemical changes of the blood are negligible. Roentgen ray evidence of bone involvement may often be found in the femur, vertebra, tibia, and humerus and occasionaly in the skull, pelvis and mandible. The earliest and most consistent finding is the "Erlenmeyer flask" deformity of the lower part of the femur. Pains in the bones also may occur as well as pathologic fractures. The distinctive pathologic picture facilitates a definite diagnosis, if one keeps in mind the clinical findings. The presence of the enlarged spleen and/or the abnormal blood picture should lead to a bone marrow biopsy. This procedure is much safer and just as reliable as a liver or splenic puncture.[6] While the characteristic foam cells are occasion-

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ally found in lymph nodes, the peripheral nodes that are available for biopsy rarely are involved.

There are no specific methods of therapy although many measures have been tried. Splenectomy continues to be a helpful palliative measure. It has usually been advised only when the size of the spleen was large enough to produce mechanical symptoms or when uncontrollable purpura was present.[7] Recently, recognition of the presence of secondary hypersplenism in some cases of Gaucher's disease has given added incentive to splenectomy.[8, 9]

Report of Case

Mrs. W. R. B., a white, married woman aged 30, was first seen in August 1950, complaining of frequent vague attacks of indigestion occurring over a period of eight years. The examination showed a small, thin, nervous woman with the only abnormal finding being a palpable spleen extending 4 to 5 cm. below the costal margin. The blood count, urinalysis, serologic examination, chest film and complete roentgen ray studies of the gastrointestinal tract gave negative results.

In May 1951, the patient was referred by her dentist for checking of a bleeding tendency. A tooth needed extraction, and he recalled that at a previous extraction there had been considerable difficulty in controlling the bleeding. She also had a severe postpartum hemorrhage with one of her four children. In addition, she had, at times, noticed black and blue marks appearing for no particular reason. Friends had also remarked about how yellow her skin appeared during the attacks of indigestion.

The blood count showed a hemoglobin of 11.9 Gm., red blood cells, 4,410,000, and white blood cells, 3,700. The differential count was normal. The bleeding time was 4 minutes and 20 seconds. The clotting time was 6 minutes and 40 seconds; the platelet count was 97,000. The clot failed to retract in 24 hours, but showed some retraction in 37 hours. The tourniquet test gave positive results. The prothrombin clotting time was 19 seconds for the patient with 13 seconds for the control. Results of the fragility test were normal. A bone marrow specimen aspirated from the crest of the ilium was reported by the pathologist as being a full, normal marrow with the presence of megakaryocytes and cells characteristic of Gaucher's disease.

On physical examination, the spleen was again palpable and about the same in size. The liver was also palpable just below the costal margin. There were several ecchymotic areas scattered over the trunk and extremities. The skin showed a peculiar tanning over the exposed areas. There were no pingueculae and no palpable lymph nodes.

When she returned a few days later, for reports on the bone marrow, she had started menstruating. The menstruation was accompanied by numerous clots and cramping. Although her periods were usually regular and normal, this period was two weeks overdue. She was admitted to the hospital. The hemoglobin at that time was 12.3 Gm., the red blood cells, 3,960,000, and the white blood cells, 8,350; the differential count was normal. The platelet count was 211,500. The bleeding time was 2 minutes and 45 seconds, and the clot retraction was normal. The reaction to the Friedman test was positive. Roentgen ray examination of the bones most frequently involved gave negative evidence. Because of persistent vaginal bleeding, a therapeutic abortion was performed, followed by splenectomy. The pathologic examination of the spleen showed the presence of Gaucher cells occupying approximately nine tenths of the structure in the sections examined.

Recovery was uneventful. The blood picture has continued to be normal. The lowest platelet count since splenectomy was 169,000 with it usually ranging between 200,000 and 300,000. There has been no further evidence of bleeding. The patient has continued to have many functional types of complaints. Some of these suggested the possibility of bone involvement: however, repeated roentgenograms have failed to show evidence of such invasion. A repeat bone marrow aspiration from the sternum about one year following splenectomy still showed a normal full marrow with widely scattered Gaucher cells.

Discussion

If the incidental finding of an enlarged spleen during the first examination for unrelated symptoms had been followed by a bone marrow biopsy, the disease in this case would, no doubt, have been diagnosed earlier, during the absence of symptoms attributable to it. As it was, the diagnosis resulted from the necessity of a tooth extraction, the past history of bleeding difficult to control, and the finding of a thrombocytopenia. The pregnancy was, of course, incidental although the abortion may have been precipitated by the presence of the thrombocytopenia. Because of the persistence of vaginal bleeding, in spite of the return of the blood picture to normal, it was believed advisable to perform a therapeutic abortion.

At this point, the advisability of splenectomy had to be considered. A large symptomatic splenomegaly which might require splenectomy was not present. The blood picture had, however, shown the presence of thrombocytopenia with purpuric manifestations. This complication, in older texts, was usually attributed to the infiltration of Gaucher cells into the bone marrow, thereby interfering with the function of the marrow and resulting in one or more cytopenias.[7, 10]

When severe enough, splenectomy was then considered, but not without considerable thought.

If one accepts the bone marrow specimen as representative of the entire marrow, there was no evidence of replacement of the normal marrow with Gaucher cells. In fact, they were widely scattered in both marrow studies. On the other hand, there were present splenomegaly, a thrombocytopenia, and the absence of impaired bone marrow as demonstrated in the aspiration studies. This triad of findings suggests the presence of hypersplenism, in this case secondary to Gaucher's disease.[3, 11] In addition, some have suggested the necessity of demonstrating sequestration of blood elements in the spleen by means of the epinephrine test; however, the absence of this finding does not exclude the diagnosis and has frequently failed to show consistent, well defined or conclusive results.[3]

Hypersplenism is a syndrome in which there is an overactivity of the normal functions of the spleen. This relationship of the spleen to the definitive blood picture has long been recognized, although the exact mechanism by which the spleen produces this effect is not entirely known. Two possible means by which this control is produced have been advanced. First, it may be due to the phagocytic and possibly sequestration functions of the spleen. Second, there may be some form of hormonal influence arising within the spleen and carried via the blood stream to the bone marrow where it acts to inhibit the maturation and development of the definitive cellular elements of the blood.[8]

By removal of the spleen, the hematologic picture may be returned to normal when hypersplenism is present. In fact, this is an essential part of the syndrome. It is also thought that the presence of this syndrome, whether chronic or acute and regardless of spontaneous remissions, may be considered an indication for splenectomy since once involved in this pathologic overactivity, the spleen is never again to be trusted. Sooner or later, a sudden hematologic crisis will occur.[9] Indeed, prophylactic splenectomy may well be indicated prior to the development of the hypersplenic syndrome and before the spleen has reached sufficient size to produce symptoms mechanically.[8] This conclusion is based on the long natural course of the disease, if complications are avoided, and consideration of the advances in surgery which have made splenectomy a relatively safe procedure, plus the fact that the spleen is neither essential to human health or longevity, nor are there any contraindications to its removal at any age.[9]

Of course, one cannot escape the fact that splenectomy does not represent a cure. It is possible that after splenectomy, infiltration of the bone marrow may eventually lead to further hematologic disorders. In addition, some believe that hypersplenism is not just the result of the overactivity of the spleen alone, but due to disorder of the reticuloendothelial system as a whole.[12] If so, further hypersplenic episodes may occur, although the possibility does not appear to be great. This involvement may account for some of the failures of splenectomy. On the other hand, contrary to some statements, splenectomy is not followed by increased invasion of the bone marrow.[6, 13]

Summary

In summary, a case of Gaucher's disease is presented, and this condition is reviewed, particularly in the light of the concepts of hypersplenism which help to reaffirm the advisability of splenectomy even early in the course of the disease prior to the development of definite symptoms or complications.

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Discussion

DR. JAMES B. LEONARD, Clearwater: Dr. Logan's paper refreshes the memory concerning the finer points of Gaucher's disease and also presents for consideration several practical problems. The first is in regard to diagnosis. In order to make the diagnosis of Gaucher's disease, one must first think of Gaucher's disease. It is not a common condition. One can confirm his suspicions by finding the typical cell in a preparation from aspirated bone marrow.

After the diagnosis is made, the problem of management becomes a real one. Sooner or later in the course of the disease, the question comes up as to whether or not a splenectomy should be performed, even though the spleen is not enlarged to the point that it is necessary to remove it for mechanical reasons. Production of the so-called hypersplenic state may cause severe anemia or a pancytopenia, as Dr. Logan has remarked. If the anemia arises from a true hypersplenism, one has a definite objective test in the Coombs test to determine the presence of antibodies. In thrombocytopenia, however, there is no such objective test, and one would have to rely only upon the presence of well developed megakaryocytes within the marrow in the absence of platelets in the peripheral blood. I think the question of splenectomy here will probably remain an individual one and a matter of judgment in each case.

DR. JOHN B. ROSS, Jacksonville: This is an excellent resume of Gaucher's disease. From the hematologic point of view the problem presented by Dr. Logan's patient is one which comes up more and more frequently, that is, whether or not to remove the spleen which apparently is causing a good deal of damage, in this case thrombocytopenia.

As far as I can gather from the literature, most patients with Gaucher's disease who have thrombocytopenic purpura respond to splenectomy. Patients with other forms of splenomegaly who have thrombocytopenic purpura, for example some patients with chronic leukemia,

will respond to splenectomy with an elevation of platelets and a diminution of the bleeding tendency. At the present time, however, there is no reliable way of knowing in advance which patients will respond to splenectomy and which ones will not, although we know that many of them will.

The concept of hypersplenism and thrombocytopenia has received much stimulating research in the last three years. Workers in St. Louis, in Dr. Carl V. Moore's laboratory, discovered that patients with idiopathic thrombocytopenic purpura have something in their blood stream which, when injected into a normal person, causes the platelets to diminish and which seems to damage the megakaryocytes as well. From that basic observation a platelet agglutinin was discovered. In the near future some simple test based on platelet agglutination will probably make it possible to follow patients with thrombocytopenic purpura and also perhaps will indicate which patients will respond to splenectomy and which patients will not respond.

Preliminary Survey and Analysis of 200 Consecutive Physical Examinations

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This paper originated from a question in my mind as to how many people actually have family doctors. When I decided to ask this question in the course of a series of physical examinations, I thought I might as well assemble some other data at the same time. The greatest single source of error in the paper is due to lack of foresight and preparation in the collection of data. I should like to know when I have finished if you think the information gained would justify a longer series studied after thorough overhauling and improvement of the history-taking methods and technic. In this series, of 200 persons interrogated, 133, or two thirds, said they had no family doctor locally, about one half named a specialist in obstetrics and gynecology and a few named a pediatrician. This tabulation was made without regard to age or sex. On the face of it, this result does not coincide with previous ideas I have heard expressed, and I suspect that my sampling did not cut across all economic levels evenly enough.

One factor which may have a bearing here is that 138 persons, or just over two thirds were not Orange County citizens, and many of these, on further questioning, said they had a family doctor back home. Even with these included, it seems that the general practitioner is not getting around as he should.

In this consecutive series, the 200 persons had only one thing in common; they all wanted to work for the City of Orlando. Except for applicants for the police and fire departments, who have to pass a most rigid examination, the examination was the stand up and strip. inspection type used in army induction centers. Women were examined on a table and seen only with a nurse present. Roentgen study, urinalysis, Kahn test, sight screening, blood pressure determination, temperature, pulse and respiration were also routine.

The examinations were made in 1952 between February 7 and September 30, a period of less than eight months for 200 examinations. Since the total force of city employees is only around 700, this seems to be a tremendous turnover, approximately 30 to 35 per cent a year. Actually, the skilled labor group of 53 persons has a rather small turnover, and the unskilled labor group has a larger turnover even than is indicated here. That is because only a few specialized jobs with the city pay enough to compete with private enterprise.

The ratio of men to women (190 to 10) in this series is a little lower than the actual employee ratio for an interesting reason. One or two department heads persist in ignoring the fact that city ordinances require a pre-employment physical examination. These departments hire and use only secretaries and/or stenographers. They are all women, and the ones employed during the period of this series were not examined.

There were 22 rejections. Seventeen of these were mandatory by civil service rules, that is, police and fire department applicants who did not come up to standard. The other 5 were persons so obviously hopeless as to be a major hazard to the city. The rejection rate would have been much higher if a good healthy labor pool existed, but there is no point in rejecting 5 or 6 poor specimens and then being forced eventually to pass one just as poor.

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Three points that go hand in hand and should be mentioned because they tend to shape the statistics are: (1) the engineering department hires the greatest number of employees, (2) hires on a job basis and (3) uses mostly unskilled male day labor. These facts explain the 650 to 750 variation in the total of city employees, the large number hired, 138, and ratio of men to women.

In spite of the transient nature of the large body of subjects, 124, almost two thirds gave a history of previous inoculation with tetanus toxoid. This question was asked because it is standard practice to give all employees in potentially hazardous jobs either a course of toxoid or a booster shot on employment. The number in this large transient group seems to indicate that tetanus toxoid is widely used in industrial medicine.

One rather reassuring bit of information was the general connubial state. One hundred forty-eight were married, and only 3 admitted divorce. I did not get into the number of marriages per person, or the number who were single because they had just gone their separate ways.

When I first plotted the age grouping, it was suggestive of the bell curve, but with one strange defect. I could not explain why there were so few in the 31 to 35 year group. It seemed to be too high an age group to be affected by military service unless there was a hangover effect of the World War II casualty rate. This group would be aged 21 to 25 in 1942. I would not have expected such a decided break in the curve because of combat losses in this age group alone. Combat losses should surely show in the five year groups above and below. With this thought puzzling me, I broke the age grouping down further and plotted each individual age. An entirely different pattern was evident, and I think it means only that men hate to grow old just as much as women. As becomes apparent, the numbers in each age seem to dam up against the even decades and then fall off sharply.

Physical Defects

Physical defects listed on the subjects' cards were not minor. They were only noted if severe enough to require attention or threaten city liability. Tooth and gum disease was much the most frequent finding. I think the poor state of oral hygiene found calls for major action in this field of Public Health and Welfare.

The lower extremity group represents a job lot of defects and diseases. Over 50 per cent had flat feet; hammer toes were frequent. Surgery of the knee was noted five or six times. One applicant in this group had a sixth toe bilaterally, confirmed by roentgenogram, and bony spurs on the fifth metacarpals. Another had typical saber shins and also Hutchinson's teeth. Varicose veins were so prevalent they were given a separate listing; 64 of the 200 examined had varying degrees of varicosities, totaling more than all other lower extremity defects.

There were only 2 inguinal hernias, and the patients were operated upon before being employed. In 24 more, however, inguinal rings were large enough to merit being noted as potential hernias. Of 10 other hernias, 7 were small congenital umbilical protrusions and 3 postsurgical.

One applicant had active syphilis. Several others with a history of syphilis had negative reactions to the Kahn test.

There were 2 in the series with active tuberculosis. Only 4 could be said to be malnourished.

The frequency of defects is much more interesting. Only 24 persons had nothing serious enough to merit listing. Twelve of these were applicants for the police or fire departments, and 6 were skilled laborers, 3 of the 6 being women. Fifty-nine persons received credit for only one defect. Forty-six persons had 2 defects, and an equal number had 3. Twenty-five had 4 or more. The great majority of defects noted were either of the developmental or cardiovascular-renal degenerative type.

Summary

This report covers a tentative survey and analysis of a series of 200 consecutive physical examinations performed on prospective employees of the City of Orlando. The study was made in an effort to find some order in a rather haphazard employment system and to find out what type of help the city generally was getting and how it was being used. The socioeconomic aspects of the study seem to make sense, and it is believed that attention to some of the findings could improve the efficiency of the total labor force. Difficulties were encountered in obtaining the medical history because of reluctance on the part of the applicant to furnish the information sought. The physical findings generally need more minute breakdown to be of statistical value.

As a whole the survey provides a base line for a definite study and points up several corrections and changes which should be made in the methods of obtaining the necessary data.

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Retirement: When and When Not to Retire
Reflections of a Retired Physician

Meyer Golob, M.D.
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As may be gathered from the title, this paper is concerned primarily with the practice of medicine. It touches upon the wider scope of the subject of retirement only by implication.

To begin with, it is only fair to admit the limitations under which I labor in an attempt to treat the topic objectively, for with me retirement has been only a matter of months. How valid, it may be asked, can conclusions be, when drawn from a single case, of short duration, and based upon one's personal reactions? It is hoped, however, that this analysis may serve as a mirror in which others may view themselves more clearly.

Retirement Forced by Economic System

By far the most compelling cause of retirement among physicians is that which has been operating to displace the much coveted incentive of private enterprise upon which the medical profession is patterned. The numerous Cancer Detection Clinics which have grown up in our big cities and their environs have caused a tapering off in private offices for cancer detection to the point of mere palpability.

While the medical profession as a whole affirms the great benefit in educating the public to a timely and early detection of cancer, and looks upon the medical check-up that is attended with adequate screening procedure as the sine qua non for the maintenance of good health, it cannot fail to realize how deeply private practice has thereby been affected. I wish to emphasize that I have no cavil with the work of the great clinics; but when they outstretch the hand of charity without regard to the economic status of the recipient, they cannot remain free from censure. The well minked, the well jeweled, the well housed are treated along with those economically distressed; and the needy who are guilty of procrastination of their own, and who should receive early attention, are often subjected to additional and harmful delay.

As we physicians well know, prognosis in any malady, particularly in malignant disease, is directly proportional to earliness in diagnosis and treatment. In cancer, said Charles H. Mayo, you "either cure or console." We give due consideration to the former, and humbly resort to the latter. It is not uncommon to find a case in which the patient delays several months after the onset of symptoms. The corner pharmacist is all too often the symptom therapist. Further delays by the clinic in late admission may be climaxed by inoperability. Yet, in popular opinion, that clinic ranks high, "where appointments are given months in advance."

A Sampling of the Cancer Detection Clinic

As advertised in the newspapers, white collar workers can still get a break. Swamped by the rising cost of living, unable to pay standard rates for expensive diagnostic tests, and not eligible for charity, the white collar man and woman in need of medical aid face a critical problem. For the past six years the hospital has been operating a specially designed, custom-tailored diagnostic clinic for the forgotten man of society, at the moderate flat rate fee of $65. As many of the tests are extremely expensive, this service has attracted not only the white collar man but also many a well-to-do patient, into whose affluence the hospital does not attempt to inquire.

What this trend has done to private practice can well be imagined. It is no easy task for a physician to combat such rivalry by mere reliance on trustworthy medical treatment. It is against this background, at a time when one's medical career has touched the yellow leaf, when the middle class withdraws its patronage, and when the poor are graciously diverted by him to the outpatient department of the Cancer Detection Clinics, that the private physician must consider the problem of retirement.

Retirement and Its Implications

Retirement based on physical inadequacy must be accepted graciously. Common sense should tell us that instead of waiting until we are eligible for the "Cane and Crutch Brigade," we should con-

sider retirement as indicated when our physical or mental energies can no longer cope effectively with the tasks confronting us. When the law of diminishing returns has attained momentum, when the services rendered are becoming incommensurate with the energy expended, it is wise to accept retirement as the inevitable reward. The physician has done his life's work; now let him relax, if he can.

There is also the small number of physicians whose affluence, amassed or inherited, enables them to decide upon voluntary retirement. Free from economic insecurity, they may reasonably look forward to the pleasures of travel, to see what the rest of the world looks like and how things are done in other lands. But let them not depend too strongly upon the thought that "idleness is the most natural aspect of life." The burden imposed on other physicians by the economic struggle for existence has most likely dwarfed whatever inclinations toward idleness they may have had as their natural endowment.

It is an indisputable fact that one's reaction toward retirement depends largely upon the nature of the individual. Chronic boredom might delight X but discomfort Y; and no common denominator can help us to determine the reactions of a person who has broken off all connection with his life's work. "We psychiatrists," wrote Abraham Myerson, "are fond of the slogan 'adjust to reality'; but whose reality must one adjust to? The reality of the predatory and acquisitive is different from that of the gentle and self-denying, that of the monk is not that of the pleasure-seeking hedonist, nor does the devoted wife of a philosopher agree with him as to the validity of their respective realities."

The balance sheet on retirement, if carefully audited, will disclose liabilities as well as assets emerging in bold relief; as to which will be predominant will depend on many factors, including the temperament of the individual. The following instance of retirement by persuasion may be illuminating: Mr. A retired at 64. He soon complained of gastric distress, indifference to food, a distaste for meat, diminished alertness, and a feeling of inferiority. Though well provided for by his children, he felt 'humble' and depressed. Physical findings were essentially negative, and a general laboratory work-up was unremarkable except for hypochlorhydria and low basal values. Upon the advice of his physician, he took up some sort of employment in his son's business. A subsequent examination of the patient showed him to be psychically rehabilitated. He lost his stomach consciousness, and time moved rapidly on the job.

The physician contemplating retirement when he still possesses the vigor and will to serve may find himself in the position of Mr. A. Forty years of medical practice have most likely rendered him unsuitable for a life of "sun-baked idleness," and retirement is not always the opportunity to have our life "mellowed and softened as with sunset glow." Too active for too long, he cannot easily adapt to a useless life without suffering the ills of accelerated deterioration. Mental as well as physical ailments may intrude more readily when one gets the feeling that his usefulness to society has come to an end.

Of course he still has the opportunity for hobbies, and if he cannot entirely dispel the feeling of uselessness, he might at least keep from succumbing to sheer idleness. But here again there are difficulties. The change from worker to hobbyist may be too great a transformation at an age when adaptability is no longer a prime characteristic. Radio programs may feature "Life Begins at Eighty." Poets may sing in soothing tones: "Nothing is too late, till the tired heart shall cease to palpitate." Instances may be cited of an achievement made at 90; but these exceptions operate mostly when one's life-long field of endeavor is continued, not when given up for something new, at an advanced age. Klumpp, writing on "Longevity and Its Problems" in the February 15, 1953 issue of the New York State Journal of Medicine, weightily observed: "Retirement is a successful experience for those who have been wise and foresighted enough to plan for it. But what they have planned for is most often merely a different kind of occupation. It is sometimes euphemistically called a hobby, which is nothing more than work with the sting of need taken out of it."

Prevailing on the aged to join a club for the 'oldsters' is in my opinion an instance of psychiatry in reverse. While he still mingles in social groups not exclusively aged, he may continue to harbor the illusion that his activities are not unlike those of society as a whole, even though conducted at a slower tempo. But when thrown into an environment exclusively senile, he can hardly escape the depressing feeling that the sun is setting alike to all.

A Voice from a Lay but Honorable Congressman

In the Congressional Record for March 3, 1952, the Hon. Emanuel Celler queried: "HAVE

WE FAILED OUR AGED?" "Despite all the evidence around us," he said, "we persist in thinking of ourselves as a country of the young." Maintaining that "chronological age tells very little about energy-age, mental-age, usefulness-age," he urged us to stop thinking in terms of groups, placing one group in a box and labeling it this, and placing another group in another box and labeling it that, for "each person is an individual — a unit of heart, mind, body, and soul, regardless of age." I wrote to the Congressman that we not only injure our senior citizenry, but we fail to utilize our resources in skilled man power.

Scientifically speaking, there can be no argument against the view that social age is only roughly related to chronologic age. Chronologically, the man may be 50 years of age, and only his arteriosclerosis makes him biologically old. "Man is never too old to learn," said the great Dr. Mayo. "In all individuals," Wechsler avers, "there is the great need of hurdling difficulties, all the way from the cradle to the grave, which stand in the way of adaptation to reality. . . . Inability to make the hurdle often leads to flight from reality into the arms of fantasy and neurosis." That a retiree gravitates toward neurosis is not an uncommon observation in the practice of medicine.

Our Present Muddled Situation

Let us bear in mind the fact that life expectancy has risen from 45 to 70 in the last 50 years. The average life is easier, more enjoyable, and considerably longer. When formerly a man in the forties looked old and felt old, and was expected to age rapidly, he is now regarded as still in the prime of life — a valuable member of society.

This remarkable improvement in human growth would be an even greater blessing if it were not for the fact that our institutions have been designed for a shorter life span. We enjoy the expanded experience of the automobile age, but are constrained to travel along the antiquated horse-and-buggy roads. As I view the intriguing subject of combined gerontology and geriatrics, the problem of age must be linked with the problem of proper utilization of man's skills in the national interest. We read, for example, of "Doctor Shortage," and learn that it is particularly acute in Veterans Administration hospitals; yet it is made impossible for older, skilled physicians to reduce these shortages. While the aged no longer feel up to the doctor's normal 14 hour day, many of them are in excellent health, and are much imbued with the problems of medicine, as they have been for many years. Yes, we oil the squeaks that arise when the machinery is not working smoothly, but we do not cast it aside. We iron out the wrinkles and creases of a garment, its integrity still retained; we do not discard it. But the physician who has reached his 65 or 70 is dropped from our professional institutions as of little worth.

It is only during our epidemics that we become vocally alarmed about the doctor shortage. Yet that shortage exists in normal times, too, if we are genuinely concerned about public health and are willing to expand our efforts for preventive and curative medicine. The responsibility for combating malignant disease, for example, is even more incumbent upon the physician than upon the patient himself, for it is the former who can study those "subtile tissue changes of early cancer," which are easily missed on a cursory examination, and who "literally holds the person's life in his hands." My associates and I, in a study of an analytic survey of 104 cases at the Metropolitan Hospital in New York City, published in The Review of Gastroenterology, March-April, 1942, showed that all presented themselves with a textbook syndrome of inoperable cancer, a tragic feature so well demonstrated by complications and sequelae of a nonreversible malady. One of the conclusions that the study drew merits reiteration: "Cancer mindedness is the straight path to early diagnosis in a history characterized by vagueness. A physician's mind should be a balanced mind on a universal joint. It should swing in any direction to which the symptomatology might point. We agree with MacCarthy '. . . that clinical behavior is our only standard for interpreting morbid anatomical pictures. The two are inseparable.' " We might condone a delay by the patient in seeking advice in "31.2%" of cases in the year 1948, but a delay in "23.4%" of cases by the physicians should not escape arraignment. In the opinion of the writers the goal of making the office of every physician a cancer detection center can never be reached if his practice demands that he see 30 to 100 patients a day during his office hours. Those patients suffer of 'doctor shortage.' When early and timely detection of cancer is perniciously cast aside, it is largely a case of shortage.

We are well familiar with the delays engendered by economic shortage. We lament the shortage of physicians needed for military service, but we do nothing to lower the obstructions to a continued utilization of our older colleagues. The number of active years of medical practice that

would accrue from the fringe of the medical rank and file — the geriatric component — would materially dull the keen edge of shortage, even if they were employed but four hours a day.

While the subject under discussion has been treated on the Platonic principle of 'Know Thyself,' personal communications from two physicians add interest. "Sorry to hear of your coming 'holiday,'" said one. "Dad [also a physician] retired some three years ago and is faced with the problem of making life interesting." The other, an aged physician himself, wrote: "No matter how old a person may be, his greatest asset is to be short of time; his main liability is to have time in excess. Find some pleasurable outlook and pursue it: Conversation with friends, the life of ants, or bees or fish, bygone days, historic gems of poetry or philosophy — anything to keep you busy; and I hope you will stop vacationing."

If we would only stop counting birthdays, the setting sun of the geriatric, regardless of the segment of humanity to which he belongs, would not be lacking in radiance. But, as already alluded to, men are 'time subjects,' and time bids us 'be gone.' Let us remember that retirement is the kind of a garment that fits only when custom-tailored; only then will our new years of longevity add "life to years, as well as years to life."

1739 Southwest Twenty-First Street

ABSTRACTS OF MEDICAL ARTICLES

What the General Practitioner Should Know About the Management of Allergic Skin Disorders. By Wiley M. Sams, M.D. South. M. J. 46:620-624 (June) 1953.

Since the general practitioner sees and adequately cares for a large majority of patients with skin disease, in diagnosis he encounters the problem of separating the acute from the chronic disorder, the contact dermatitis from atopic dermatitis, and allergic disorders from those that are nonallergic. He should be equipped, in the opinion of the author, with a clearcut, concise definition of allergy. Furthermore, he should have the ability to explain it to his patient in every day, common terms and then tell him how it applies to the condition which he may present for investigation. A plea is also made for more and earlier attention to the subject of allergic disorders in the curriculum of medical schools.

Allergy is defined as an altered state of reactivity, and in any living organism which comes into contact with a foreign substance, either by external or internal exposure, there may develop one or more alterations. The type and character of the ensuing reactions and the disorders they produce in the living organism are extremely varied and of fundamental significance in many fields of medical endeavor.

Various manifestations of allergic dermatitis, etiologic problems and appropriate therapy are discussed. Successful management is described as including (1) exclusion of the activating agent, if it is known; (2) treatment of the dermatitis which exists; and (3) the selection of therapeutic agents which are unlikely to precipitate future or additional trouble.

X-ray Therapy in the Treatment of Hemangiomas. By Wesley W. Wilson, M.D. South. M. J. 46:464-468 (May) 1953.

A series of 200 cases is reported in which infants were treated for hemangioma with low voltage roentgen therapy. The inadvisability of waiting for angiomas to disappear spontaneously is pointed out, for such a "wait and see" policy may result in trauma followed by infection, ulceration, pronounced scarring and disfigurement.

In this series, treatment was begun before the patient was six weeks of age in 24 per cent of the cases, before the age of seven months in 58 per cent, and before the age of 13 months in 18 per cent. In but 1 per cent was there secondary infection after therapy was begun; in these 2 cases it was mild and readily controlled by antibiotics and the roentgen therapy. In 14 per cent, however, secondary infection was already moderately

advanced before treatment was instituted; poorer cosmetic result was obtained because of extensive tissue destruction by ulceration.

Since in treatment of all the angiomas it is imperative to remove the lesion with the least cosmetic defect, in no instance should there be haste in carrying out therapy which may damage underlying tissues. It is concluded that low voltage roentgen therapy given in conservative dosage is an effective means of treating many of the hemangiomas, and the results shown by using this method indicate that this procedure gives excellent therapeutic and cosmetic results.

Otitis Externa, Bacteriological and Mycological Studies. David E. Singer, M.S., Elizabeth Freeman, M.S., Warren R. Hoffert, M.S., Reginald J. Keys, M.S., Roland B. Mitchell, Ph.D., and Albert V. Hardy, M.D., Dr. P.H. Ann. Otol., Rhin. and Laryng. 61:317-330 (June) 1952.

In recent years there has been a new appreciation of the importance of otitis externa as a disease entity. Its occurrence with disturbing frequency among troops in the South Pacific and also in civilian practice in widely scattered localities during hot, humid summer months has made it an acknowledged problem of military and civilian medicine. New therapeutic measures and simple in vitro sensitivity tests now available, however, offer hope of specific and more effective therapy.

During the summer and fall of 1951, the authors examined bacteriologically and mycologically 1.377 cultures of the normal and 646 of the diseased external ear. Pseudomonas, other gram-negative bacilli, and streptococci were identified rarely from the normal but frequently from the infected external auditory canals. There was no increase in prevalence of other bacteria in the infected ears.

The Pseudomonas group of organisms appeared to be the most important etiologic agent, but other gram-negative bacilli and streptococci apparently also had etiologic significance. Mycologic flora was sparse and diverse and appeared to have limited etiologic significance.

In vitro sensitivity tests performed on all bacteria isolated pointed to terramycin and sulfadiazine as the drugs of choice for otitis externa. It was concluded that initial cultures and sensitivity studies are indicated to guide therapy in the less typical cases.

The Changing Problems in Public Health. By Wilson T. Sowder, M.D. South. M. J. 46:589-594 (June) 1953.

After pointing out that the South has had more than its share both of public health problems and regional disease problems with basic resources to meet them less than the average for the remainder of the country, Dr. Sowder expresses the conviction that the South, with more to do and less to do with, nevertheless has led the nation in the public health field for the last quarter of a century. The health departments have escaped hampering political dictation in his opinion because those in the field of public health have earned the respect of all political factions by honest toil and professional competence. In addition, he regards the South as the native habitat of the full time local medical health officer, as well as the stronghold of the unified and consolidated city-county-school health department. Also, compared to the other sections of the country, the record in specific death rates and rates of disease incidence are good, certainly so in view of the relative standing a decade ago.

On the other hand, he notes an undertone of worry today, particularly on the part of physicians in public health, about what the future holds. With a long-continued era of expanding budgets, expanding staff, and expanding programs now curtailed by an increasing demand for economy after years of increasing inflation, with growing personnel problems, especially recruitment of public health physicians, and with lay health officers thrust into the picture in other areas, the outlook to those with a defeatist attitude, he concedes, may not seem too bright.

After expressing opposition to the principle of the appointment of lay health officers at county, district or state levels, Dr. Sowder expresses confidence that the South will hold the line and adhere to the principle of full time local medical health officers. For them he pictures a career of subtle charm and lasting satisfaction and outlines the many facets of a constructive program to absorb their time and energies. He counsels that they constantly survey the problems, programs and methods of attack and make necessary changes to meet in the difficult years ahead the great need for the sound leadership so ably demonstrated in the past.

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The County Medical Society

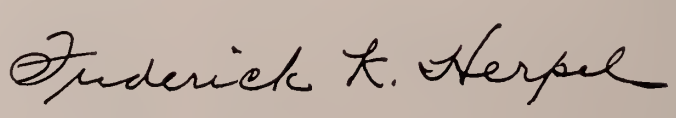
The basic unit of medical organization is the County Medical Society. Only through membership in a county society can one have a voice in the deliberations and actions of organized medicine. Suggestions for improvement in medical practice come primarily from members of such societies. You are a part of some medical society, and owe it to yourself to become familiar with all phases of its activity. Membership has its privileges, its duties and its responsibilities.

The secretary of your society, through whose office comes all information from higher levels of medical organization, is an important officer of your society. The manner in which communications are handled, conscientiously and expeditiously, determines whether you are kept informed about our problems on a national and state level, and what action you should take to assist in the carrying out of determined policies. The position of secretary is one not to be filled lightly, on the spur of the moment during an annual election of officers, but to be filled by one chosen because of special ability, and one in whom you have every confidence.

Each society should have a designated body, executive committee preferably, whose responsibility it shall be to see that all communications are carefully read, their importance to the society and its membership determined, and decision made concerning those communications which deserve discussion in open society meetings. Complaints directed to the society, or to any of its members, should be forwarded to the Mediation or Grievance Committee of the society for its immediate and careful consideration, to the end that justice be served. In many instances the physician will not be at fault, but in others disciplinary action of the society, toward some one of its members, may be recommended.

Your state committees and your officers are always most happy to lend you what assistance they can in the solution of your problems, if you have made a real effort to solve them at the county level, and have failed of a solution.

Again, holding meetings of county societies in conjunction with hospital staff meetings defeats the purpose of such meetings. Scientific programs should be an integral part of each county medical society meeting. All too frequently medical societies have permitted hospital staffs to take over the presentation of scientific programs, leaving to the county society meeting only the dry, and sometimes dull, routine of medical business. A well planned meeting, with a scientific program, will do much to revive waning interest in county societies. Someone will have to do some work to make this possible. You have a voice in organized medicine, if you will only exercise it. Pull on your oar. The boat is lopsided if you are resting on your oar, and criticizing the work of those who are trying to help you and help the cause of medicine in America.



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"My Country, 'Tis of Thee"

November brings perennially the nation's annual Thanksgiving Day. This occasion calls especially to mind foundation stones characterizing our national life, on which every true American would do well to reflect not seasonally but day in and day out.

"My country, 'tis of thee, Sweet land of liberty, Of thee I sing; . . ." But do we? It is easy to render lip service to this "Land where my fathers died, Land of the Pilgrim's pride," but deep down in our hearts how lustily do we sing, "From every mountain side Let freedom ring?"

History is, in essence, a chronicle of ideas. The dramatic story of the growth of this country and of its evolution as the foremost nation on earth might well be titled the biography of an idea. From the beginning that basic idea has been and today continues to be the freedom of the individual. The measure of its realization enables every patriot to declare, "My native country, thee, Land of the noble, free, Thy name I love, . . ."

Across the years men have seen in America the promise of a better life for themselves and their families. To them this country has offered a share in its abundance with the possibility of individual economic freedom and security in old age. The essential dignity and worth of human beings is our heritage, and this idea has colored all the efforts of the men who have built the nation.

The paths trod by our forefathers through the years have not been without their pitfalls and troubles. The transformation of a wilderness into the energetic and dynamic economy of today has been beset by wars, pestilence, depressions and scores of other disasters. Nevertheless, the striking feature is that despite these setbacks, progress has continued so that now this land of the free stands at the forefront among the nations of the earth.

Physicians in this country today have but to look around the world and be thankful they are Americans. Recent experiences, however, have taught them that even in the homeland their rugged individualism and freedom to practice their chosen profession without governmental interference are a precious heritage which comes at a price. When danger was upon them from within the nation, they were quick to prove again that, from the very beginning, this country has grown and prospered because its people learned to join together to plan for their future security and to protect the ideals of the Founding Fathers. In accordance with the true practices of democracy, the doctors pooled their individual efforts to become the nation's vanguard in meeting an insidious but none the less vicious onslaught upon the American way of life.

Certainly it is timely to give thanks for the

American heritage and for the privilege of safeguarding American values. At the same time, there is the perpetual obligation to the profession, to the community and to the nation to emulate the past, exemplify the best in the present, and insure for the future that "Long may our land be bright With freedom's holy light."

Progress of Voluntary Health Protection in 1952

The substantial part of the nation's health bill cared for in 1952 by voluntary health protection reflects the inherent vitality of this movement in this country. The American people voluntarily increased their protection against the unexpected costs of hospital, surgical and medical care to new record high levels last year, and every section of the country participated in the gains.

Cash benefits flowing from voluntary health protection aggregated some two billion dollars during the year, according to the Health Insurance Council's annual survey of accident and health coverage in the United States released late in September of this year. Approximately half of this amount helped to meet the cost of hospitalization, and the remaining billion was divided about equally, one half covering operations and doctors' bills and one half representing benefit payments by insurance companies replacing income lost because of accident or sickness.

By the end of last year the number of persons covered against hospital expense approached the 92 million mark, a figure which had increased by five and a half million, or 7 per cent, over 1951. More than 73 million persons were protected against the cost of operations under surgical expense coverage at the end of 1952. Included in this number were seven and one-half million persons added during the year, representing a gain of 12 per cent over the preceding year. The number of persons protected against doctors' bills under medical expense coverage increased during the year by approximately eight million to a total of nearly 36 million. This gain represented an increase of 29 per cent over 1951. There was also a new high mark of more than 38 million for those protected against loss of income due to disability.

In addition, the year 1952 saw increasing public acceptance of major medical expense coverage, for persons with this form of protection numbered nearly 700,000. This newest kind of voluntary health protection is designated catastrophic insurance and is designed to complement the usual hospitalization, surgical and medical policies by helping to meet extremely serious illness.

In Florida at the end of 1952, persons who had protection numbered 1,078,000 with policies covering hospital expense, 824,000, surgical expense, and 544,000, medical expense.

The organizations covered in this survey were insurance companies, Blue Cross, Blue Shield, and various other independent plans sponsored by business and industry, employee benefit associations and private group clinics. Nine associations in the insurance business made up of companies writing the various forms of protection against hospital and medical costs and the loss of income due to disability comprise the Health Insurance Council under whose auspices the survey was made and the report drafted. From its offices at 488 Madison Ave., New York 22, free copies of the report are available.

"Little Confidence in the Doctors"

Behind the Iron Curtain, it grows increasingly difficult for physicians to exercise their profession according to pre-Communist standards. As would be expected, the medical profession there is undergoing revolution and regeneration. Political reliability is now a necessary adjunct to professional skill as a qualification for good positions in hospitals. All interns entering a hospital "are carefully screened by a committee composed of janitors, clerks and nurses."

The medical care and insurance systems in Poland and Czechoslovakia have serious deficiencies. A Prague publication, for example, on March 5, 1953 published this comment on the new reorganized health service: "Public ignorance of the new organization is still serious. The workers do not know whom to approach in case of illness, where to find a practitioner, where to apply for new glasses, etc. Frequently, a patient goes from one medical center to another wasting precious working hours. One of the main shortcomings is still the lack of a good relationship between the medical workers and the patients, and the lack of kindness and sympathy for the ill person. This is the reason why patients have little confidence in the doctors."

Since Communist absorption took place in Poland, physicians are under the supervision of so-called "elements of social vigilance." No free medical associations exist. In Rumania, political

indoctrination courses are compulsory, and failure to pass them means dismissal from medical school.

This evaluation of medical practice in Soviet-dominated satellites came from a former professor of pediatrics at the Charles University in Prague, who is now practicing in this country. The information was made available by the American Heritage Foundation of New York City. Free medicine may well dedicate itself anew to a social vigilance that will keep it free.

Secretary Hobby Predicts Social Security Priority

In the opinion of Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare, legislation to extend social security will have high priority with the Congress when the next session opens in January. The proposal under consideration, presented in the closing days of the last session but too late for action, has the strong support of President Eisenhower. This plan would extend Old Age and Survivors Insurance to ten and one-half million more persons, including physicians, dentists and many other groups of self-employed.

Mrs. Hobby, in two addresses in the early fall, predicted prompt action. At a Republican party rally at Kiamesha Lake, New York, she said social security extension would be among the first matters to come up for decision in January. "This bill," she added, "which is in line with the President's campaign promises, will, if passed, give the advantages of social security to more than ten million Americans who at present are left out of the system. These include many self-employed professional people — doctors, lawyers, accountants, dentists, etc.; self-employed farm operators and hired farm workers; a large number of household workers not now covered, and possibly four million state and local government workers." Addressing the American Federation of Labor convention a few days later, the Secretary again stated that social security extension would be pressed by the administration.

Under the chairmanship of Representative Carl Curtis of Nebraska, a House Ways and Means subcommittee is continuing its study of the whole social security structure, preparatory to reporting to the Congress soon after the first of the year. Chairman Reed of the Ways and Means Committee introduced the social security extension bill "by request."

Survey of Physicians in Service

Analysis of the results of the first six months of a continuing survey of physicians separated from active military service has yielded noteworthy data. Of approximately 5,000 questionnaires sent out by the Council on National Emergency Medical Service of the American Medical Association, 66 per cent had been returned as of July 15, 1953.

These questionnaires sought to cover (1) general information concerning the physician; (2) the extent of military training, branch of service and rank; (3) type of work performed while in service, efficiency of utilization, percentage of time spent on the care of military personnel, dependents and other types of beneficiaries, and staffing conditions for physicians and allied health personnel; and (4) comments and suggestions regarding the Armed Services and the part which the medical profession should play through its organizations.

For those responding, 23 months was the average total time spent in service; 15.6 months was the average tour of duty in the United States, and 7.4 months was the average tour of foreign duty. Exclusive of time spent in an Army or Navy specialized training program, 15.7 months was the average time spent in active service. The majority thought they were properly assigned and rotated, and 636 physicians expressed their willingness to remain in service for more than two years.

Only half of those who returned the questionnaires replied to a question designed to obtain suggestions on how medical societies may be of greater help to doctors in service. The suggestions most frequently offered were "request for more information, personal visits by civilian physicians to evaluate grievances, invite physicians in service to civilian medical meetings, assist in preventing evasion of military service, provide specialists for clinical conferences."

The reply to the inquiry about over-all staffing conditions was: overstaffed, 23 per cent; understaffed, 25 per cent; adequately staffed, 52 per cent. Of the comparatively few who offered additional remarks, 53 seemed dissatisfied with military service and 171 seemed satisfied with their tour of duty.

As it gains in perspective, the general picture emerging from this continuing survey should evoke wide interest and merit careful study.

Veterans Medical Care

How much does a free country owe its veterans for having helped to preserve its freedom? How much does the veteran still owe his country which grants him a freedom greater than anywhere else in the world?

Many physicians have had the privilege of wearing a uniform, voluntarily or otherwise. We, too, are veterans. Does that entitle us to a free ride at public expense for the rest of our lives? Should that grant us privileges from a benevolent Congress denied other citizens and taxpayers? Who gains and who loses by class legislation which sets us apart — even from our own families?

The medical profession agrees that the federal government should provide the finest medical care available to veterans whose ailments are a result of military service. It seriously questions the advisability of any person receiving medical care and other considerations not available to all the citizens if his ailments are not service-connected or service-aggravated.

The United States is rapidly becoming a nation of veterans. As of Aug. 21, 1953, there were over 20 million veterans of military service out of an over-all population of 160 million. That is one out of every eight men, women and children. Approximately 80,000 are being added each month — a million a year.

Can even a rich nation stand the terrific financial strain? If present benefits are continued, the taxpayers of this country will shell out more than a trillion dollars for the veterans of World War II alone. In 1953 the Congress appropriated $692,499,200 for the Veterans Administration medical program. In 1952, this government agency spent $178,000,000 on care of service-connected disabilities and more than $322,000,000 on care of veterans whose ailments were unrelated to military service. On the basis of percentage of cases, the figures are even more startling. Past records of the Veterans Administration indicate that approximately 85 per cent of the patients in its hospitals are being treated for non-service-connected disabilities. Its medical program is second in size and expense only to the nationwide system of socialized medicine in Great Britain.

Recognizing the seriousness of the situation, the House of Delegates of the American Medical Association in June 1953 recommended that the Congress enact legislation limiting Veterans Administration medical care and hospitalization benefits to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or service-aggravated, and to veterans with wartime service suffering from tuberculosis or psychiatric or neurologic disorders of non-service-connected origin who are unable to defray the expense of necessary hospitalization, provided that treatment is given within limits of existing facilities.

The task of disseminating accurate information on this problem to the profession and the public has been delegated to the Committee on Federal Medical Services of the Council on Medical Service of the American Medical Association, of which Dr. Louis M. Orr of Orlando is chairman. In order to begin carrying out the charge of the House of Delegates, Dr. Orr called a conference on Veterans Medical Care in Chicago on September 1, at which 37 state medical associations were represented. Following this meeting, it was deemed advisable to schedule follow-up regional conferences after the representatives had an opportunity to determine the thinking of the profession in the several states. A meeting of the Southeastern states is scheduled for Atlanta on November 8. Every interested physician is urged to attend.

The Congress is in recess. Your Congressmen and your Senators are at home. Their presence in the state affords every doctor an excellent opportunity to bring this matter to the attention of our lawmakers. They will welcome your views.

A. M. A. Clinical Session St. Louis, Dec. 1-4, 1953

Plans move ahead for the annual Clinical Session of the American Medical Association in St. Louis, December 1-4. The Jefferson Hotel has been selected as the headquarters hotel. The sessions of the House of Delegates will be held in the Gold Room of that hotel, and all Reference Committees will also meet there.

From all indications the meeting promises to be an outstanding one, says Dr. Llewellyn Sale, in charge of local arrangements. The Kiel Auditorium provides ample facilities for all scientific activities, including the lecture program, scientific exhibits, technical exposition, motion picture program, and television program.

The program for clinical presentations and color television will cover the fields of medicine, surgery, pediatrics, obstetrics and gynecology, tuberculosis and other diseases of the chest, car-

diovascular diseases, arthritis, dermatology, gastrointestinal diseases, and neuropsychiatry.

The scientific exhibit will be correlated as far as possible with the clinical presentations. There will be a group of 75 or 80 exhibits relating to these presentations in the various fields mentioned. In addition, there will be several special features. As usual, a special exhibit on fractures will be shown under the direction of the fracture exhibit committee, composed of Dr. Gordon M. Morrison of Boston, chairman; Dr. Ralph G. Carothers, Cincinnati, and Dr. Herbert W. Virgin, Jr., of Miami.

An exhibit symposium on the prevention of traffic accidents is a contemplated feature. It is planned to include the responsibility of the physician in telling his patient when not to drive and what other precautions should be taken in special situations, the testing of the drinking driver, precautions to be taken by automobile manufacturers in the reduction of mechanical hazards, and the care of the injured by physicians after an accident. Cooperation of the various agencies interested in the problem will be discussed, such as the National Safety Council, the traffic division of the police, and the various medical groups that have been attempting to solve the problem.

Medical motion pictures will be shown continuously. The authors will be present, whenever possible, to discuss their work.

In 1954, the Clinical Session will come to Florida. At this time next year Miami will be busily engaged in preparing for this annual major medical event. Then all Florida physicians will be within easy range, and many will be able to take advantage of this exceptional opportunity to attend.

Public Relations Conference St. Louis, Nov. 30, 1953

The sixth annual National Medical Public Relations Conference sponsored by the American Medical Association will be held in St. Louis on the last day of this month, the day before the Clinical Session opens there on December 1. The meeting will be held in the Jefferson Hotel.

The conference program will be geared primarily for physicians. A cordial invitation to attend is extended to members of the House of Delegates, officers of state and county medical societies, officers of the American Medical Association, and executive secretaries and public relations personnel.

Duval County Medical Society Plans Centennial Celebration

The year 1953 marks the one-hundredth anniversary of the Duval County Medical Society. Plans are well under way for an outstanding Centennial Celebration next month featuring a nationally prominent guest speaker. The program is expected to have such appeal to the public and the profession alike that the George Washington Hotel Auditorium will be the scene of the meeting.

The Duval County Medical Society is the oldest medical society in Florida and among the few medical societies in this section of the United States that have been active for a century. Not only did its founding mark the beginning of organized medicine in Florida, but its history takes on added significance in that it was the only medical society in the state for two decades and through the efforts of its members the Florida Medical Association was founded 21 years after it was organized.

Noteworthy across the years is the number of leaders in the medical profession who have been both outstanding physicians and outstanding citizens and civic leaders as well. To cite an early example, one has but to begin to recite the many interests and accomplishments of Dr. A. S. Baldwin to prove that for the 60 years during which he was active in Jacksonville, he was the city's most prominent citizen.

The Duval County Medical Society thought this centenary occasion an appropriate time to issue a book depicting the march of events across the last century, both medical and otherwise, with a background of Florida's colorful history antedating that period. Its Centennial Committee, of which Dr. Webster Merritt is chairman, has been active in the preparation of this publication for the last 10 months. The book will be chiefly pictorial, having approximately 100 illustrations in addition to photographs of some 60 past presidents of the society which have been collected over the last several years. It will be off the press in mid-November and should have as wide appeal to the laity as to the profession.

The Editor Invites Your Contributions on Data of Notable Interest

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Public Health Physicians to Organize

Physicians engaged in full time public health activities have been invited to attend a meeting at the Hotel Statler in New York on November 9 to discuss and map future plans for the formation of an American Association of Public Health Physicians. This evening meeting is scheduled to coincide with the meeting of the American Public Health Association.

Formation of the American Association of Public Health Physicians has been in progress since the fall of 1951. The Board of Trustees of the American Medical Association supported the proposal in principle on Feb. 8, 1952, and heartily endorsed the association.

American Academy of Sanitary Engineers

Plans are now complete for the certification of sanitary engineers and the formation of the American Academy of Sanitary Engineers. The Joint Committee for the Advancement of Sanitary Engineering reached agreement on final details at a recent meeting and announced: "The purpose of the certification will be to confer recognition on those engineers who have achieved recognized competency in the specialty field of sanitary engineering, just as the specialty boards of physicians and dentists now designate those who have achieved acknowledged abilities in segments of their profession."

Parents Take Note

A Children's Bureau report shows that the accidental death rate for children is being reduced only about one third as fast as the rate for death by disease. In the decade 1940-1949, the Bureau reports, accidental deaths of children were reduced 16 per cent while the rate for all other causes of death was being reduced 46 per cent.

Are You Receiving Your Journal?

If you are not receiving your copy of The Journal, it is probably due to a new postal regulation under which postmasters return only the address label from publications which could not be delivered because of an incorrect address. Formerly copies of The Journal were returned with postage due. Under the new regulation The Association must guarantee both forwarding and return postage to make certain The Journal is delivered to members and subscribers or returned to the Association office.

Considerable clerical work is required to make address changes. In order to avoid needless delay in delivery of your Journal and much added expense, The Journal suggests that all doctors and subscribers inform this office as soon as possible of any contemplated change of address.

A change of address form is carried on page 346 of this issue of The Journal. If your address has been changed or will be changed in the near future, please fill it in and forward it to The Florida Medical Association, P.O. Box 1018, Jacksonville. Your cooperation will assure you of receiving each copy of The Journal promptly and will mean a considerable saving in mailing cost.

Graduate Medical Education

The eighth annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach the week of Jan. 18, 1954. The lectures on Ophthalmology will be presented on January 18, 19 and 20, and those on Otolaryngology on January 21, 22 and 23. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 20, to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p. m. on Wednesday.

The Seminar lecturers on Ophthalmology this year are Dr. W. B. Anderson, Durham, N. C.; Dr. W. P. Beetham, Boston; Dr. W. C. Owens, Baltimore; Dr. A. B. Reese and Dr. M. C. Wheeler, both of New York City. Those lecturing on Otolaryngology are Dr. E. N. Broyles, Baltimore; Dr. H. P. House, Los Angeles; Dr. W. J. McNally, Montreal, Canada; Dr. Dorothy Wolff and Dr. D. Woodman, New York City.

* * *

The Diabetes Seminar will be held again this year with the cooperation of the Florida Clinical Diabetes Association, the Florida Medical Association, the Florida State Board of Health and the Department of Medicine of the Graduate School of the University of Florida. Tentative plans are for the meeting to be held in Orlando probably in April.

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Because the annual meeting of the American Medical Association, scheduled for San Francisco June 21-26, 1954, is later than usual, the date for the Twenty-Second Annual Graduate Short Course will probably have to be changed either to two weeks prior to or two or three weeks after that meeting.

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The Tri-State Obstetric Seminar was held September 14-16 at the Sheridan Beach Hotel in Daytona Beach. The total attendance of 253 included physicians and nurses. Ninety-six Florida physicians were in attendance while Georgia had 33; South Carolina, 14; and other states, 10. The Program Committee consisted of Dr. E. Frank McCall, Jacksonville, Chairman; Dr. Hilla Sheriff, Maternal and Child Health Director, South Carolina; Dr. Helen W. Bellhouse, Maternal and Child Health Director, Georgia; and Dr. R. W. McComas, Maternal and Child Health Director, Florida. The program covered heart disease in pregnancy, surgery, anesthesia, pediatrics, care of the premature infant and mortality trends in the tristate region.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Morris J. Levine of Miami announce the birth of a son, Richard Allen, on July 6, 1953.

Dr. and Mrs. Robert V. Artola of West Palm Beach announce the birth of a daughter, Consuelo Marie, on Aug. 30, 1953.

Dr. and Mrs. Tyndall P. Harris of Jacksonville announce the birth of a son, Tyndall Peacock, Jr., on Sept. 18. 1953.

Dr. and Mrs. Grover C. Collins of Palatka announce the birth of a son on Sept. 24, 1953.

Dr. and Mrs. William J. Phelan of Jacksonville announce the birth of a daughter, Mary Catherine, on Sept. 28, 1953.

Dr. and Mrs. Jerome H. Newman of Jacksonville announce the birth of a daughter, Debra Jo, on Oct. 5, 1953.

Dr. and Mrs. Karl B. Hanson of Jacksonville announce the birth of a daughter, Evelyne St. John, on Oct. 10, 1953.

Deaths — Members

Green, Thaddeus H., St. Petersburg ..... Sept. 16, 1953
MacVeany, Arthur P., Miami ..... Sept. 22, 1953
Grove, Helen I., Largo ..... Sept. 30, 1953
Goodale, Banks H., Jacksonville ..... Oct. 8, 1953

Deaths — Other Doctors

Browning, Zack C., Augusta, Ga. ..... April 30, 1953
Marion, John F., Marion, N. C. ..... June 2, 1953
Koon. Alpheus C., Lakeland ..... Sept. 19, 1953

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, Raymond T., Coral Gables
Barry, Andrew J., Starke
Bryant, Henry H., III, South Miami
Carson, Doris N., Jacksonville
Coffey, Jerome J., Hollywood
Cooke, Francis N., Mami
Cooksey, Charles D., Jacksonville
Dayton, Helen C., Miami
Dortch, Hugh, Jr., West Palm Beach
Emmel, George L., Gainesville
Gillman, Aron N., Miami
Gittelson, George, Miami
Kellerman, Edgar A. P., West Palm Beach
Lamb, William E., Jacksonville
McNaughton, Robert A., Miami
Nash, Norman, Miami
Norris, Alfred W., Hastings
Owen, Richard D., Fort Lauderdale
Rimer, Harry B., Miami Beach
Robak, John L., Miami
Russell, Robert M., Lake Butler
Russman, Howard B., Coral Gables
Schwartz, Stanley E., Miami Beach
Skyer, Joseph R., West Palm Beach
Snyder, Kenneth E., Coral Gables
Thompson, Ronald MacK., West Palm Beach
Tippett, Samuel N., Surfside

Medical Officers Returned

Dr. Rex E. Myers, Jr., who entered military service on June 1, 1951, was released from active duty on May 31, 1953 with the rank of captain (U. S. Army). His address is 4209 San Pedro, Tampa.

Dr. James M. San who entered military service on April 30, 1953, was released from active duty on Aug. 21, 1953 with the rank of captain (U.S.A.F.). His address is 3014 Estrella St., Tampa.

Dr. Thomas C. Frell, who entered military service on March 20, 1953, was released from active duty on Sept. 14, 1953 with the rank of captain (U.S. Army). His address is 25 E. 2nd St., Hialeah.

STATE NEWS ITEMS

The scientific program of the fall meeting of the Florida Academy of General Practice was held at the Floridan Hotel, Tampa, on September 13. Drs. Leonard L. Weil of Miami Beach and Frank T. Linz of Tampa were in charge of the program which was a Symposium on Cardiovascular Diseases. Speakers and their subjects were Drs. Walter W. Sackett, Jr., Miami, "Acute Heart Failure;" T. D. Sandberg, Coral Gables, "Hypertensive Heart Disease;" Leonard L. Weil, Miami Beach, "Myocardial Infarction;" Daniel H. Zimmerman, Miami Beach, "Some Causes of Degenerative Heart Disease;" Leon S. Eisenman, Okeechobee, "Valvular Heart Lesions and Congenital Heart Diseases;" and David Brezin, Miami, "The Surgical Heart."

Dr. David R. Rothrock of Miami entered medical service with the U. S. Army on July 5, 1953 with the rank of captain. He is stationed at Camp Pickett, Va.

Dr. Samuel R. Lamb of Jacksonville entered medical service with the U. S. Navy on Oct. 27, 1952 with the rank of lieutenant.

Dr. Arthur J. Butt of Pensacola was a guest speaker at the Northeastern Section Meeting of the American Urological Association at Shawnee-on-Delaware, Pa., and the International College of Surgeons in New York, where he spoke on "Newer Concepts Concerning the Role of Urinary Colloids in the Etiology of Renal Lithiasis."

Dr. Henry I. Langston of Marianna is taking nine months postgraduate training in Public Health Administration at the Tulane University of Louisiana School of Medicine in New Orleans.

Dr. Wilson T. Sowder of Jacksonville spoke on gamma globulin at a meeting of the Rotary Club of Tampa in August.

Dr. James H. Miller, Jr., of Dunedin has returned to his practice after attending a two-week refresher course on fracture cases at the Shortell Hospital in Boston.

Drs. John F. Lovejoy, George I. Raybin, Richard G. Skinner, Jr., and Bernard L. N. Morgan of Jacksonville all took part in a "field clinic" sponsored by the Florida Crippled Children's Commission in Palatka in August.

Drs. Leffie M. Carlton, Jr., C. Frank Chunn, Frank T. Linz, W. Mahon Myers, Charles L. Pope, Philip L. Smoak, Wray D. Storey and Marshall E. Smith, all of Tampa, took part in a panel discussion on cancer at a meeting of the Palma Ceia Kiwanis Club in Tampa in September.

Dr. Fred I. Dorman, Jr., of Lakeland spoke on polio at a September meeting of the Lakeland Jaycees.

Dr. N. Worth Gable, St. Petersburg, spoke to the members of the Duval County Medical Society in Jacksonville on October 6 explaining the technicalities of putting on a medical forum. Prior to the county society meeting Dr. Gable met with the Duval County Medical Society Forum Committee comprised of Drs. G. Dekle Taylor, chairman, Raymond R. Killinger, Ashbel C. Williams, Floyd K. Hurt, Joseph J. Lowenthal and Mason Romaine, III.

The mid-winter meeting of the Florida Obstetric and Gynecologic Society will be held at the Orange Court Hotel in Orlando, December 5 and 6. The meeting will open at 2 p.m. Saturday and close at noon Sunday. The program will be presented by Drs. Frank R. Lock, Professor of Obstetrics and Gynecology, Bowman Gray School of Medicine of Wake Forest College; Robert B. Greenblatt, Professor of Endocrinology, University of Georgia School of Medicine; and Dr. W. Nicholson Jones, Professor of Gynecology, Medical College of Alabama.

Any member of the Florida Medical Association who includes obstetrics and gynecology in his practice and wishes to be a member of this Society should write for an application to: Dr. J. Champneys Taylor, Secretary, 1022 Park Street, Jacksonville.

Dr. Clarence M. Sharp of Jacksonville is the new president of the Southern Tuberculosis Conference.

Dr. R. J. Wilkerson, past president of the Southern Medical Association, died in Huntington, W. Va., recently following a heart attack.

Dr. Joshua C. Dickinson of Tampa has been named president-elect of the American Roentgen Ray Society.

Dr. John E. Daughtrey of Lakeland was speaker at a meeting of the Lakeland Exchange Club in September.

Dr. Samuel G. Hibbs of Tampa spoke at a September meeting of the Tampa Regional Mental Hygiene Society.

Dr. Gretchen V. Squires of Pensacola spoke on the functions of a pathology laboratory and pathologists in a hospital at a meeting of the Pensacola Rotary Club in September.

Dr. Simon D. Doff of Jacksonville spoke at a meeting of the Palm Beach County Heart Association.

Dr. John T. Stage of Jacksonville spoke on "Defibrillation" at the annual meeting of the Florida Society of Anesthesiologists in September in Daytona Beach.

Dr. Robert W. Curry of Orlando has returned to his practice after spending two weeks in Oak Ridge, Tenn., studying the technics of using radioisotopes in medicine.

Dr. Bernard L. N. Morgan of Jacksonville was guest speaker at a meeting of the Lake City Rotary Club in September.

More than 2,000 doctors attended the Twenty-Second Annual Meeting of the American Academy of Pediatrics in Miami, October 6-9. Outstanding authorities in all phases of children's physical and mental health discussed such topics as the advances in treatment of meningitis, immunization and therapeutic procedures, present aspects of therapy in rheumatic fever, respiratory viral diseases, and other important medical subjects. Members from throughout the United States, Canada, Central and South America and Cuba, as well as pediatricians from Europe and Asia attended the four-day meeting.

Dr. Wlson T. Sowder of Jacksonville has been reappointed State Health Officer for a four-year term ending Sept. 11, 1957.

The Florida Society of Anesthesiologists held its semiannual meeting at the Sheraton Beach Hotel in Daytona Beach in September. Business and scientific sessions were held as well as a cocktail party and banquet.

Dr. Jack T. Bechtel of Eau Gallie is serving as resident physician in cardiology and metabolic diseases at Duke University Hospital in Durham, N. C.

Drs. Manuel A. Schofman of Miami and James H. Mendel, Jr., of South Miami have returned to their practices after attending an intensive course in otolaryngology at the University of Illinois Graduate School of Medicine in Chicago.

Dr. Albert V. Hardy of Jacksonville has returned from a two weeks consultation in California with the Armed Forces Epidemiological Board's Commission on Enteric Infections. Dr. Hardy is director of this Commission.

Dr. Camillus S. L'Engle of Jacksonville attended the meeting of the World Medical Association in The Hague in September.

COMPONENT SOCIETY NOTES

Alachua

Dr. Nathaniel Jones of Jacksonville spoke on "Chronic Glomerulonephritis" at the meeting of the Alachua County Medical Society on September 8.

Dade

The regular monthly meeting of the Dade County Medical Association was held on October 6. A panel discussion on "The Clinical, Cardiovascular and Metabolic Effects Associated with Some Intracranial Lesions" was held with Dr.

Robert J. Boucek as moderator. Participants were Drs. Herbert Eichert, Paul S. Jarrett, and B. F. Lowenstein, and Nancy Noble, Ph.D.

Duval

At the October meeting of the Duval County Medical Society, Dr. N. Worth Gable of St. Petersburg spoke on "What Is a Medical Forum?"

The first of a series of 12 public Medical Forums being sponsored by the Duval County Medical Society and the Jacksonville Journal is scheduled for Nov. 12, 1953. The Forums have been modeled after the Pinellas Plan originated by the Pinellas County Medical Society.

Organizational details have been worked out by the Forum Committee appointed by Dr. W. W. Rogers, president of the Society. Dr. G. Dekle Taylor is chairman. Other members are Drs. Raymond R. Killinger, Ashbel C. Williams, Floyd K. Hurt, Joseph J. Lowenthal and Mason Romaine, III.

Excepting the Thanksgiving and Christmas holidays, a Forum is to be held each Thursday night in the Duval County Armory, according to plans worked out by the Committee. A list of possible subjects has been compiled and the public will be invited to submit questions for discussion through the newspaper.

Hillsborough

Dr. Hans Lowenback spoke on "The Management of Psychiatric Emergencies by Non Psychiatrists" at the joint meeting of the staff of Bay Pines Hospital and the Hillsborough County Medical Association on October 6.

Lake

At the regular meeting of the Lake County Medical Society on October 7, Drs. John N. Moore and John P. Moore of Ocala spoke on "Diseases of the Colon as Seen by the Radiologist."

A discussion was held on some form of credit bureau or disseminating agency that would be useful for the medical societies in the smaller counties.

Marion

The Marion County Medical Society met at the dinner after the Cross-Roads Cancer Seminar in Ocala in place of their regular monthly meeting in October.

Orange

The Orange County Medical Society has paid 100 per cent of its state dues for 1953.

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SITUATION WANTED: Physician, age 39, white, married, Protestant, Category 4, has Florida license, would like to find a satisfactory location in that state to practice Obstetrics and Gynecology. Graduate of the University of Virginia, trained at Duke University, and certified by the American Board of Obstetrics and Gynecology. Write 69-100, P. O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: 29, Florida license, getting out of Navy December, wishes to join group practice. Write 69-101, P. O. Box 1018, Jacksonville, Fla.

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WANTED: Association with well established internist or group by young internist, board qualified, Category IV. Prefer Sarasota or Fort Lauderdale. Write R. F. Kidder, M.D., Box 516, Perry Point, Md.

WANTED: Staff Physician. If interested, please contact the Medical Director, Florida State Hospital, Arcadia, Florida.

RADIOLOGIST: Board certified diagnosis and therapy; age 38, draft exempt, married with family; consider good opportunity for hospital or office practice or combination. Write 69-103, P.O. Box 1018, Jacksonville, Fla.



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1. Greenhill, J. P.: Principles and Practice of Obstetrics, ed. 10, Philadelphia, W. B. Saunders Company, 1951, pp. 103-104; 311; 332.

SEARLE Research in the Service of Medicine

OBITUARIES

Henry Mason Smith

Dr. Henry Mason Smith of Tampa died at St. Joseph's Hospital in that city on June 16, 1953. He was 69 years of age and had been in ill health for some time.

Born at Douglasville, Ga., on May 10, 1884, Dr. Smith was graduated from the local schools. Continuing his education in his native state, he was awarded the degree of Doctor of Medicine by the University of Georgia School of Medicine in 1908. He then came to Florida and engaged in the general practice of medicine at Milton until 1914 when he accepted a position on the staff of the Florida State Hospital at Chattahoochee. From 1917 until 1921 he served as superintendent of that institution. He was a veteran of World War I.

Since 1921, Dr. Smith had practiced in Tampa, specializing in neurology and psychiatry, and was the head of the Mason Smith Neurological Clinic there. Locally, he was a member of the staff of the Tampa Municipal Hospital, St. Joseph's Hospital and the Tampa Negro hospitals. Prominent in the social and civic life of the city, he was a member of the Tampa Yacht and Country Club and the Gasparilla Krewe.

Noted professionally throughout the South, Dr. Smith was affiliated with numerous medical organizations and through the years held many offices in them. He was a member of the Hillsborough County Medical Association. Since 1910 he had held membership in the Florida Medical Association and in 1926 served as its president. He was also a member of the American Medical Association and the Southern Medical Association, a fellow of the American College of Physicians, and a diplomate of the American Board of Psychiatry and Neurology. He was a past president of the Florida Society of Neurology and Psychiatry.

Dr. Smith is survived by his widow, Mrs. Justine Savarese Smith, and a son, H. Mason Smith, Jr., of Tampa; a sister, Mrs. Mollie Lee of Douglasville, Ga.; a brother, J. Frank Smith of Milton; and a granddaughter.

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Donald W. Hedrick

Dr. Donald W. Hedrick of Tampa died suddenly, apparently of a heart ailment, at his residence on May 27, 1953. He was 50 years of age.

A native of Ohio, Dr. Hedrick was born in Defiance on April 29, 1903. He received his medical training at the University of Michigan Medical School and was awarded the degree of Doctor of Medicine in 1928. Before coming to Tampa in 1949 to practice orthopedic surgery, he was associate in orthopedics for 17 years at the Henry Ford Hospital in Detroit, Mich.

In the practice of his specialty in Tampa, Dr. Hedrick was associated with Dr. Frank H. Lindeman. He was on the staff of St. Joseph's Hospital, Tampa Municipal Hospital and Tampa Municipal Negro Hospital. Also, he was civilian orthopedic consultant at MacDill Air Force Base. Active in the civic and social life of the city, he was a member of the Tampa Rotary Club, Greater Tampa Chamber of Commerce, Tampa Yacht and Country Club and Spectators Club. His fraternity was Nu Sigma Nu. He held membership in St. Andrew's Episcopal Church.

Dr. Hedrick was a member of the Hillsborough County Medical Association, the Florida Medical Association, the American Medical Association and the Southern Medical Association. In addition, he was a fellow of the American College of Surgeons, a diplomate of the American Board of Orthopedic Surgery, a member of the Clinical Orthopedic Society, American Academy of Orthopedic Surgeons, American Rheumatism Association, and American Society for Surgery of the Hand.

The widow, Mrs. Jeane Hedrick, and two daughters, the Misses Nancy and Louise Hedrick, all of Tampa, survive. Also surviving are the parents, Mr. and Mrs. W. F. Hedrick of Bradenton.

Joseph S. Murrow

Dr. Joseph S. Murrow of Apalachicola died of uremia on May 28, 1953, at the Franklin County Hospital in that city after an illness of about a year. He was 80 years of age. Interment took place in Atlanta, Ga., with Masonic rites.

The son of a physician, Dr. Murrow was born in Pembroke, Ga., in 1872. He was educated in his native state and received his medical degree from the University of Georgia School of Medicine in 1899. Soon after graduation he came to

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GYNECOLOGY—Intensive Course, Two Weeks, starting February 15, 1954. Vaginal Approach to Pelvic Surgery, One Week, starting March 1, 1954.

OBSTETRICS—Intensive Course, Two Weeks, starting November 2, 1953, March 1, 1954.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting March 15, 1954. Two-Week Intensive Course, starting May 3, 1954. Gastroscopy, Two Weeks, starting March 8, 1954.

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Florida and engaged in the general practice of medicine in Apalachicola for 53 years. He endeared himself to the entire community and was held in the highest esteem by his fellow physicians. In the half century and more of his practice there he is said to have delivered more than 3,000 babies.

Dr. Murrow was a member of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society. He became a member of the Florida Medical Association in 1902 and for the past two years had held honorary status. He also was a member of the American Medical Association.

Surviving are the widow, the former Nell McGruder of Bainbridge, Ga.; one son, Eugene Murrow of Swanquarter, N. C.; a grandson, Joe Murrow of College Park, Ga.; and two brothers and a sister.



Lewis Palay

Dr. Lewis Palay of Miami Beach died of a myocardial infarction in a local hospital on July 16, 1953, at the age of 51. Interment took place in New York City.

Born in Cleveland, Ohio, Dr. Palay received his medical degree from the University of Louisville School of Medicine in 1928. Before becoming a Doctor of Medicine he began his professional career as a pharmacist. For many years he practiced otolaryngology in New York City.

Hoping to prolong his life, already threatened by a coronary thrombosis, Dr. Palay came to Miami Beach in 1944 and limited his practice to allergy. In 1951, he conducted a survey of pollen conditions in that area, the results of which received widespread publicity.

Dr. Palay was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He was a diplomate of the American Board of Otolaryngology, a member of the American College of Allergy and a member of the Alpha Omega Alpha and Phi Delta Epsilon medical fraternities.

Surviving are the widow, Mrs. Tedi Palay, and two daughters, Roberta and Marsha, all of Miami Beach; two sisters, Mrs. Nettie Goldberg and Mrs. Libby Schwartz, and a brother, David Palay, all of Cleveland, Ohio.

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Eston Delaney White

Dr. Eston Delaney White of Miami died on July 28, 1953 of a heart ailment from which he had suffered since 1948. He was 47 years of age.

A native of Tompkinsville, Ky., where he was born in 1906, Dr. White received his medical education at the University of Tennessee College of Medicine. He was awarded the degree of Doctor of Medicine by that institution in 1941. Following hospital training in Tennessee at Nashville and Chattanooga, he located in Miami in 1944. He associated himself with the E. J. Hall Clinic, where he engaged in the general practice of medicine. For approximately five years he had been able to practice only intermittently, but to all who knew him, friends, patients and colleagues alike, he endeared himself and presented a noteworthy example of patience, fortitude and courage.

Dr. White was a member of the Dade County Medical Association. Since 1945 he had held membership in the Florida Medical Association, having honorary status the last three years. He was also a member of the American Medical Association and was a pioneer member of the American Academy of General Practice.

Surviving are the widow, Mrs. Clara White; a brother, E. L. White, and a sister, Mrs. Franklin M. Richardson, both of Tompkinsville, Ky.

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Julian M. Ruffin, M.D., Durham, N. C.
Gastroenterology

Allan C. Barnes, M.D., Cleveland, O.
Gynecology

Walter C. Alvarez, M.D., St. Paul
Medicine

William D. Stroud, M.D., Philadelphia
Medicine

Lawrence C. Kolb, M.D., Rochester, Minn.
Neuropsychiatry

Nicholson J. Eastman, M.D., Baltimore
Obstetrics

A. D. Ruedemann, M.D., Detroit
Ophthalmology

Oscar L. Miller, M.D., Charlotte, N. C.
Orthopedic Surgery

Francis L. Lederer, M.D., Chicago
Otolaryngology

Emmerich von Haam, M.D., Columbus, O.
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Philip M. Stimson, M.D., New York
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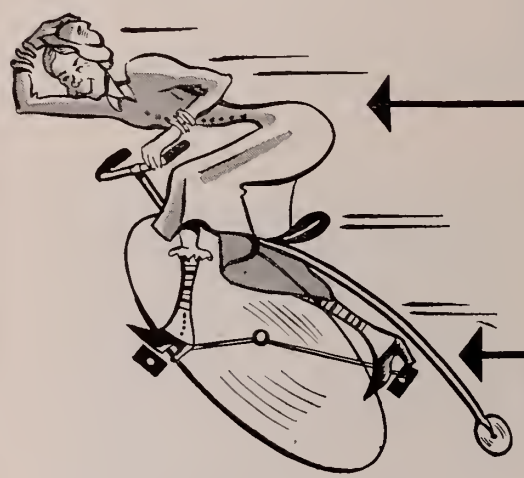
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The Little Engine That Could

At the annual meeting of the Woman's Auxiliary to the Florida Medical Association, it was reported that in all but two counties where medical societies exist the Auxiliary is active or has members-at-large.

This didn't just happen. It took hard work, tact and patience on the part of the organization committee. It required leaving homes and personal obligations, as well as a willingness to give time to other doctors' wives so that they could join the justifiably proud ladies who stand ready to assist the medical profession in its aims and objectives.

The organization committee is the ground crew who goes into "out of touch" areas and establishes communication. For the Auxiliary system is much like a railway network. It is willing to invest its facilities of transportation if the people of a certain area show inclination to travel.

Organizations, however, are like depots. Unless they are functional with up-to-date and timely information and provide good connection with the central terminal station so that the passage of valuable cargo can be transported to the proper sources in time, they are by-passed, fall into disuse and become "whistle-stops" with insignificant identification.

This dreary prospect can be avoided by a few simple precautions.

1. Keep in touch. Write the president of your Auxiliary railway and give her the names of your station master and committee engineers. Define the nature of your county so that she can provide you with as much information as the traffic will bear. She needs you and the service you can perform for your doctors in your town.

2. Take your job seriously. The president should know how to conduct a meeting, but Auxiliary members are also obligated to know how to participate in one. Friction is a danger sign of inefficiency somewhere. An engineer can run a train well if all its machine parts are in good working order, but we all know what happens to a train when it develops a "hot-box."

3. Know why you're operating and what you carry when you take off. This is a must. Acquaint yourselves with the Florida doctor's point of view. The Florida Medical Association has problems and objectives peculiar to this state, especially in public relations, which we must be careful not to complicate nor compromise with our activities.

Knowing what the County Medical Society and State Medical Association stand for is important because it determines our attitude. We are an Auxiliary *to* the Medical Association and are not permitted to operate independently of the Association's policy.

To carry information and good will wherever our tracks lead requires education, it's true; but the investment is good because it makes the difference between "take-off" and "sound-off" when we want to go places.

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From where I sit *by* Joe Marsh

Modern Art Takes a Licking!

Did you know we had a real artist in town? Yes sir! Handy Jackson was a contributor to the Sculpture Exhibition at the Fair last week.

His work was streaky pink and curved all around—sort of streamlined. Caused quite a stir. Nobody was sure what it was supposed to be, but some liked it and thought it was good art. Handy gave me the lowdown:

"Why, it was nothing but a piece of cattle salt our cows have been lickin' at for months. I just had it mounted. Fooled a lot of folks—one fellow even wanted to buy it!"

From where I sit, Handy's "modern art" just shows how some people can be led astray. Some even get to be "experts"—especially about the other fellow's business. They're quick to tell a man how to practice his profession . . . or even to interfere with his preference for a temperate glass of beer. Let's live and let live—not set ourselves up as the "model" for the other fellow.

Joe Marsh

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BOOKS RECEIVED

Modern Treatment: A Guide for General Practice. Edited by Austin Smith, M.D., and Paul L. Wermer, M.D. Pp. 1146. Price, $20.00. New York, Paul B. Hoeber, Inc., 1953.

This book is designed to provide the general practitioner with a useful and authoritative guide to the clinical problems in therapy which he is likely to encounter. The 53 authors are a group of postgraduate teachers who have joined in creating a volume which presents the practical essentials of today's therapy. In each discussion, attention is focused on the most effective treatment for the condition in the judgment of the author of the section. When appropriate, however, alternative forms of treatment are also considered, along with the author's evaluation of their role in the physician's armamentarium. The authors attempt to provide sufficient information to enable the practitioner to adapt the best available treatment to the needs of each individual patient.

The chapters have been organized to present the information in a logical sequence, as the clinical problem confronts the practitioner. Each chapter is intended to be sufficiently complete to stand by itself. The diseases discussed are those commonly encountered by the general practitioner. In some instances more exotic diseases are taken up because world travel and military commitments today increase the likelihood of their occurrence in this country.

Underlying the whole book is the principle that therapy involves much more than the simple prescription of medicaments. It is emphasized that the patient, from the time he walks in the office door until he is discharged, must be regarded as a person with a complaint or a disease and not as a piece of isolated diseased tissue which is capable of locomotion. If the practitioner has an appreciation of the treatment of the whole person, he can apply the necessary therapy regardless of the site or the extent of the disease. It is agreed that treatment of disease cannot be mechanical or distant; it must be personal and objective. It rests on many factors, but the most important aspect is judgment which rests on knowledge.

Modern Treatment is the culmination of several years of effort to provide a new kind of aid for general practice, an aid which is sorely needed in this day of breathtaking progress. Its distinguished editors are Dr. Austin Smith, Editor of the Journal of the American Medical Association, and Dr. Paul L. Wermer, Secretary of the Committee on Research of the American Medical Association.

Directory of the American College of Chest Physicians, 1952. Membership Roster published by the American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois, U.S.A. Pp. 599.

This eighth issue of the Directory of the American College of Chest Physicians contains the names and biographic data, arranged geographically, of 4,016 Fellows, Associate Fellows, Associate Members, Fellows Emeritus and Honorary Fellows of the American College of Chest Physicians in 69 countries. This represents a substantial increase over the 2,274 members in 37 countries listed in



the seventh College Directory, published in 1948. An alphabetical index is included for cross reference and convenience in locating members.

The geographical divisions of the College established by the Board of Regents, which functions under the Council on International Affairs, are listed in this Directory. A list of College chapters and their dates of charter, of past presidents of the College, of recipients of the College Medal and of dates of past annual meetings and International Congresses have been included. The Directory is published under the supervision of the Board of Regents.

Children of Divorce. By J. Louise Despert, M.D. Pp. 282. Price, $3.50. Garden City, N. Y., Doubleday & Company, Inc., 1953.

The timeliness of this unique book, the first of its kind, is emphasized by the statement in its first few lines that "there are a million and a half children of divorce under the age of eighteen in the United States, and their number is being increased by about 300,000 every year." Do children have to grow up maladjusted because their parents have been divorced? How can children be helped to absorb the experience of divorce with the least amount of damage? Why can an "emotional divorce" between parents be harder on children than an actual one?

As she answers these questions, one of America's leading child psychiatrists offers reassuring advice based on her rare insight into the problems of children of all ages. "Divorce is not another word for disaster," she concludes. In her opinion, it is, in itself, neither good nor bad; it is only what the human beings involved make of it. It is possible, she believes, for parents to make a success of their divorce even though the marriage has failed.

Rich in actual case studies, the book presents a practical discussion of how to tell a child of only two or three about a coming divorce; winning the confidence of stepchildren; the wisdom of sending children to boarding school and of moving to a new neighborhood after divorce; how to manage the father's "visitation" hours and how a father who is no longer living at home can reassure his children that he has not deserted them — that he still loves them.

Born in France, reared and educated in Paris, Dr. Despert received her medical training in New York. She has been associated with Cornell University Medical College for the past 15 years. At present she is Associate Professor of Clinical Psychiatry there and also is engaged in the private practice of psychiatry, exclusively with children. By experience as well as by temperament, she has been a consistent advocate of common sense in child psychiatry, placing emphasis in advice to parents on an understanding of the individual child.

The Conception of Disease. By Walther Riese, M.D. Pp. 120. Price, $3.75. New York, Philosophical Library, 1953.

Although the various conceptions of disease succeeded one another in the course of time, and each one represents the particular period of civilization which formed it, they have never completely passed out of existence, but live on side by side at every stage of the history of man and medicine. These conceptions are analyzed in their original setting. The part played by civilization in disease is treated in its anthropological and moral implications. Special chapters are devoted to the relationship between art and disease and Leonardo da Vinci's contributions to the genesis of the anatomical conception of disease. The author finally brings up the problem of the justification, the use and the limitations of the various conceptions of disease.

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Encyclopedia of Aberrations. Edited by Edward Podolsky, M.D. Pp. 550. Price, $10.00. New York, Philosophical Library, 1953.

Edited by Edward Podolsky, M.D., of the State University of New York Medical College and having a foreword by Alexandra Adler, M.D., of New York University College of Medicine, this psychiatric handbook offers a new approach to a comprehensive study of the ever widening field of psychopathology. This is the first systematic exposition of human aberrational behavior written for the intelligent layman as well as the expert in interpersonal relationships. In this volume are discussed all the types of aberrations, with particular emphasis on their psychodynamics. The material is arranged in alphabetical sequence for easy reference.

The Encyclopedia of Aberrations will cover all the basic manifestations of aberrational behavior, as sexual aberrations, mental aberrations, emotional aberrations, character aberrations, religious aberrations, instinctual aberrations, social aberrations, sensory aberrations, intellectual aberrations and perceptive aberrations, each described in such a manner as to convey the most important and interesting facts about the type of behavior under discussions.

From the Workshop of Discoveries. By Otto Loewi. Pp. 62. Price, $2.00. Lawrence, Kan., University of Kansas Press, 1953.

In the lecture which gives this book its title, Dr. Otto Loewi discusses the manner in which scientific discoveries are made, drawing illustrations from his own experience. The introduction to the series, which considers the study and practice of medicine from a broadly philosophical point of view, reflects the ripeness of that experience. In concluding, the author offers a synthesis of recent studies in the field of adrenal function.

Dr. Loewi, who was born in Germany in 1873, holds an M.D. degree from the University of Strasbourg, honorary D.Sc. degrees from Yale and New York University, and an honorary Ph.D. degree from the University at Graz, Austria. In 1936 he was awarded the Nobel Prize in medicine. He came to the United States in 1940 and has subsequently been Research Professor of Pharmacology in the College of Medicine at New York University. He is widely known for his important contributions to the science of physiology. The present volume is being published as Dr. Loewi completes his eightieth year.

New and Nonofficial Remedies, 1953. Issued under the Direction and Supervision of The Council on Pharmacy and Chemistry, American Medical Association. Pp. 623. Price, $2.65. Philadelphia, J. B. Lippincott Company, 1953.

This annual volume contains descriptions of the articles which stand accepted by The Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1953. Prior to the 1953 edition, it consisted essentially of two principal sections. The first section contained general statements and monographs describing actions, uses, and dosages of various drugs: the second section contained tests and standards for Council-accepted drugs for which official standards are not available. Henceforth, these two sections will appear as separate volumes. "New and Nonofficial Remedies" now contains material formerly in Section A, the Bibliography of Unaccepted Products, and index to Distributors. "Tests and Standards for New and Nonofficial Remedies" is the subject matter formerly in Section B. The decision to split the book was made after a survey indicated that interest in the book was either medical or pharmaceutical; few users found it necessary to utilize both sections to meet their particular needs.

New and Nonofficial Remedies provides the physician with such information concerning the actions, usage, limitations, and dosage of acceptable and relatively new drugs as will promote the practice of rational therapeutics.



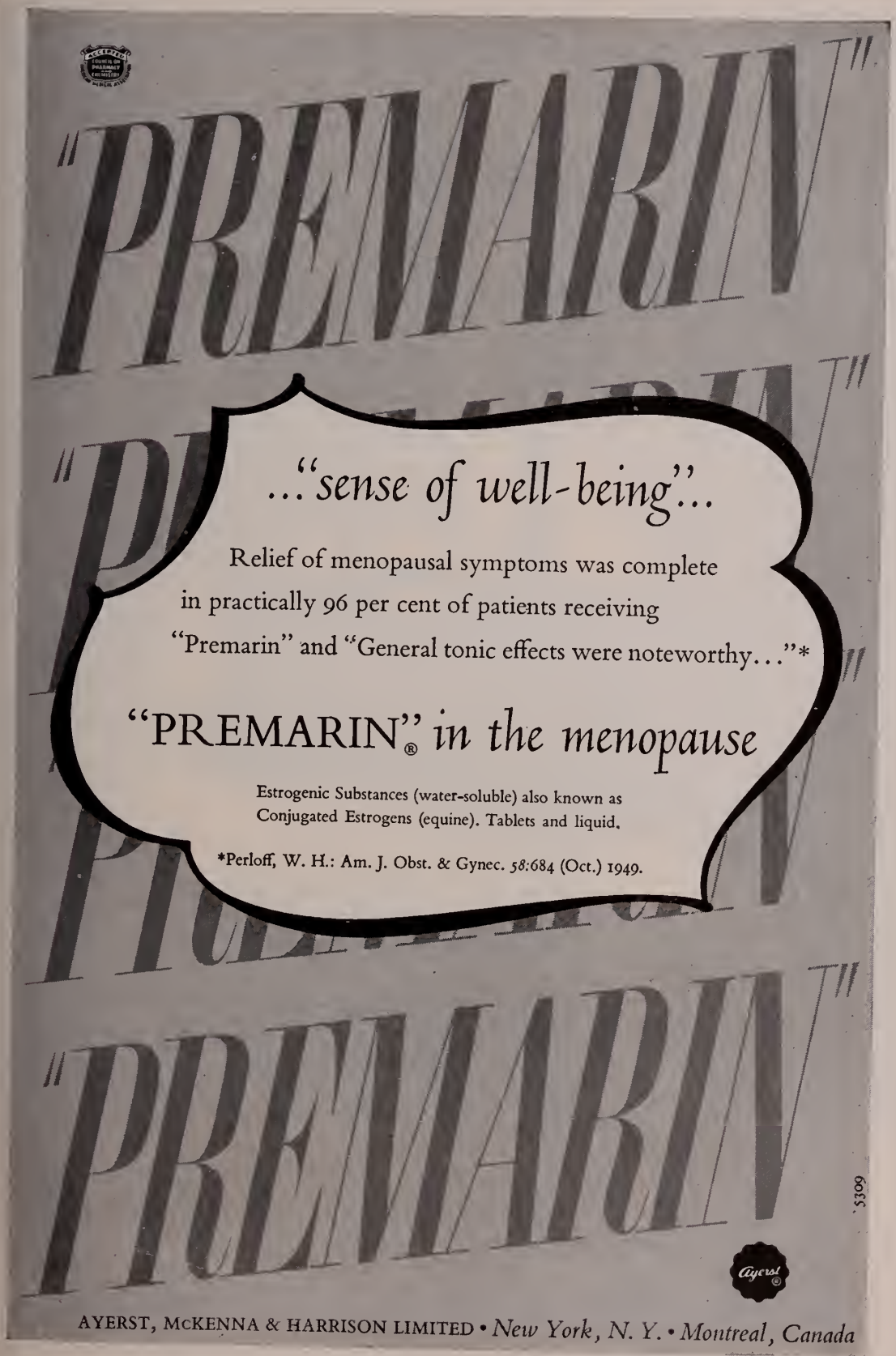
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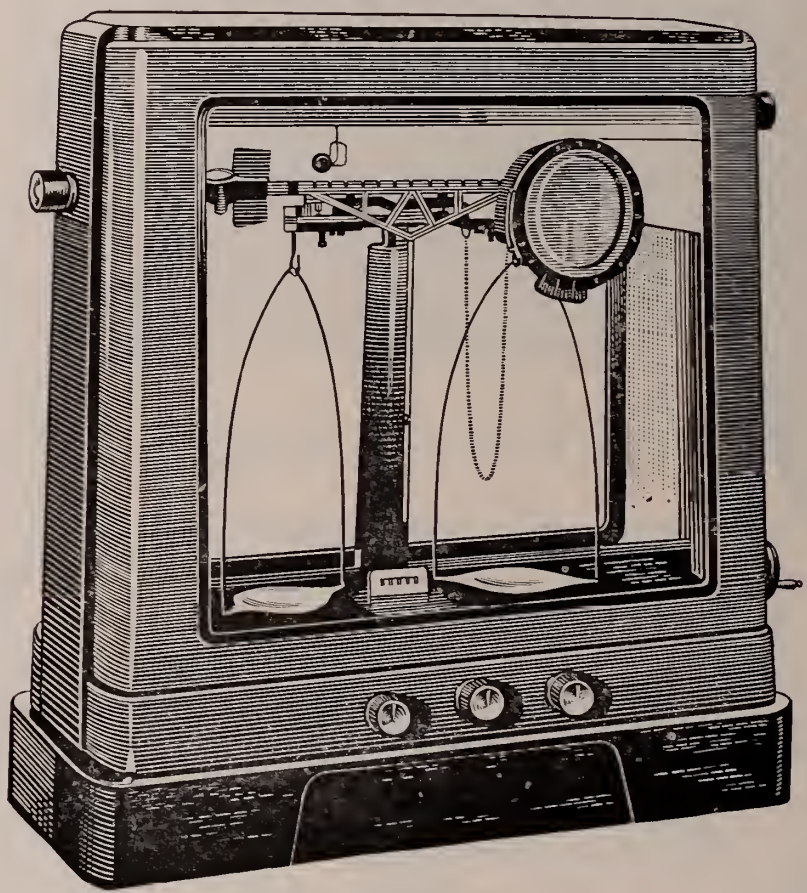
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*Perloff, W. H.: Am. J. Obst. & Gynec. 58:684 (Oct.) 1949.
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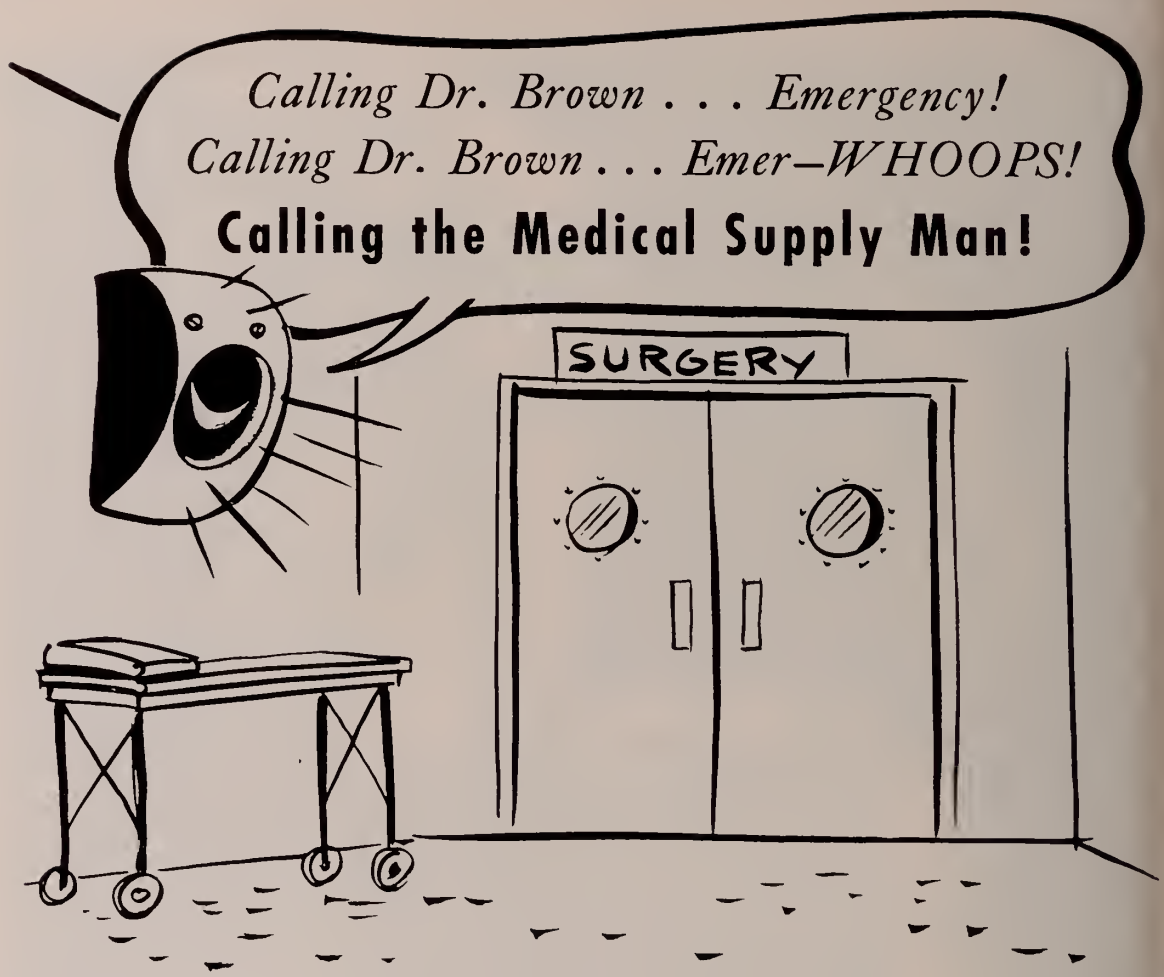
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
la Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
la Medical Districts	John D. Milton, Miami	Council Chairman	
Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	
Northeast	William C. Thomas, Jr., Gainesville	Thomas C. Kenaston, Cocoa	
outhwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	
Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	
a Specialty Societies			
my of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel, Jr., Jacksonville	Hollywood, Apr. 25, '54
y Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
esiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
er, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
rial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
logy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
d Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	Orlando, Dec. 5-6, '53
al. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	Hollywood, Apr. 25, '54
edic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	Tampa, Nov. 7-8, '53
logists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	Hollywood, Apr. 25, '54
ric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
logic Society	John J. Cheleden, Daytona Beach	George Williams, Jr., Miami	" "
ogical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
ical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
s—			
c Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, Nov. 7, '53
d Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
cer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
ical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
tal Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
rt Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
pital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	Miami, Nov. '53
ical Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson, Jr., Miami	Jacksonville, Nov. 22-24, '53
ical Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
se Anesthetists, Fla. Assn.	Miss G E. Keyes, Daytona Beach	Mrs. Lillie Crouch, Daytona Beach	Miami Beach, Dec. 3-5, '53
ses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	Tampa, Nov. '53
rmaceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
ic Health Association	Mr. Angus Laird, Tallahassee	Mr. Fred B. Ragland, Jacksonville	
leau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
erculosis & Health Assn.	Leffie M. Carlton, Jr., Tampa	Mrs. L. C. Conant, Fort Myers	St. Petersburg, Apr. 9-10, '54
han's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers, Jr., Cocoa	Hollywood, Apr. 25-27, '54
an Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
rn Medical Association	Walter C. Jones, Miami	Mr. C. P. Loranz, Birmingham	
na Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
a, Medical Assn. of	Wm. P. Harbin, Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
ospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
astern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
astern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
astern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
past Clinical Society	Hays Zieman, Mobile, Ala.	William Atkinson, Mobile, Ala	



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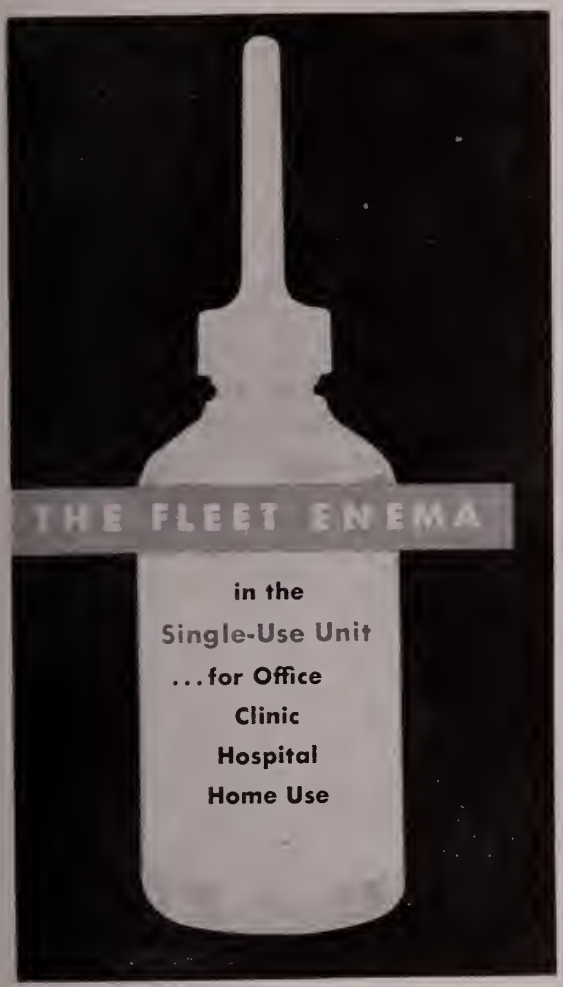
	SOCIETY	PRESIDENT	SECRETARY	MEETING DATE	MEMBERS TOTAL	MEMBERS PAID	COUNCILOR
A	Bay	Harold E. Wager, M.D. Box 984 Panama City	Charles H. Daffin, M.D. 536 E. 4th St. Panama City	1st Tuesday 7:30 P.M.	24	100%	
	Escambia *Santa Rosa*	Alvin L. Stebbins, M.D. 621 N. O St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	91	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	John W. Hendrix, M.D. Port St. Joe	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	100%	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Baylye W. Dalton, M.D. Chipley		5	100%	
	Columbia *Baker, Hamilton*	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	15	11	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James, Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher, Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	57	54	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell, Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D., Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		5	4	
	Taylor *Dixie, Lafayette*	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	100%	251
B	Alachua *Bradford, Gilchrist, Union*	F. Emory Bell, M.D. Box 113 Gainesville	Glenn O. Summerlin, M.D. 209 N. E. 2nd Ave. Gainesville	2nd Tuesday 8:00 P.M.	48	46	
	Duval *Clay*	W. W. Rogers, M.D. 313 Professional Bldg. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	265	250	
	Marion *Levy*	Eugene G. Peek, Jr., M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	27	100%	B-3-54 William C. Thomas, Jr., M.D. Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	100%	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long, Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
	St. Johns	John M. Canakaris, M.D. Box 295 Bunnell	James J. DeVito, M.D. Box 100 St. Augustine	3rd Tuesday 8:30 P.M.	16	100%	
	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	26	25	
	Lake *Sumter*	John D. Bloom, M.D. Groveland	J. Basil Hall, M.D. Tavares	1st Wednesday 7:30 P.M.	29	100%	B-4-55 Thomas C. Kenaston, M.D., Cocoa
	Orange *Osceola*	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes, Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	171	100%	
	Seminole	Wade H. Garner, M.D. Box 219 Sanford	Frank L. Quillman, M.D. Box 158 Sanford	2nd Tuesday 5:30 P.M.	18	100%	
	Volusia *Flagler*	Morris B. Seltzer, M.D. 614 N. Peninsula Dr. Daytona Beach	Robert L. Miller, M.D. 258½ S. Beach St. Daytona Beach	2nd Tuesday 7:30 P.M.	82	78	703
C	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate, Jr.,M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	178	175	
	Manatee	William D. Sugg, M.D. Bradenton Bank Bldg. Bradenton	Marjorie L. Warner, M.D. 202 Manatee Ave., E. Bradenton	2nd Tuesday 8:30 P.M.	21	100%	
	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D., St. Petersburg
	Pinellas	Everett M. Harrison, M.D. 1601 N. Ft. Harrison Ave. Clearwater	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Mon. Even Mo. 1st Fri. Odd Mo. 6:00 P.M.	203	201	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	47	44	
	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	100%	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan, Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	30	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	93	618
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts, 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Graham W. King, Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	128	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	17	16	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	99	98	
	Dade	Ralph W. Jack, M.D. 603 Dade C'wealth Bldg. Miami	Walter W. Sackett, Jr., M.D. 603 Dade C'wealth Bldg. Miami	1st Tuesday 8:30 P.M.	646	613	D-8-55 Russell B. Carson, M.D. Fort Lauderdal
	Monroe	Joseph L. G. Lester, Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	14	13	912

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1. Burnikel, R. H. & Sprecher, H. C.: Am. J. Dig. Dis. 19:191, 1952
2. Marks, M. M.: Am. J. Dig. Dis. 18:219, 1951.
3. Marks, M. M.: Personal communication, 1952-1953.
4. Sweatman, C. A.: J. South Carolina M. A. 49:38, 1953.
5. Hamilton, H., in Trans. 5th Am. Cong. Obst. & Gyn., Mosby, 1952, p 69.

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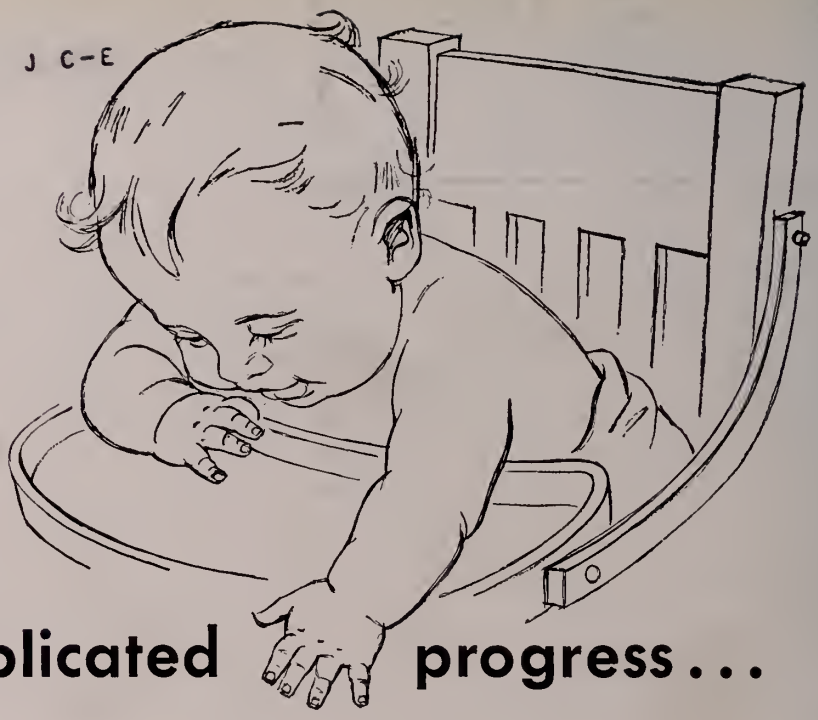
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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592, 1951.



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The Journal
OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XL DECEMBER, 1953 No. 6

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Ultrasonic Therapy
Kenneth Phillips

Snake Bites in Florida
Edwin H. Andrews and C. B. Pollard

Management of Hypertension
John S. McMichael

The Beloved Physician
Editorial — Frank G. Slaughter

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Volume XL DECEMBER, 1953 No. 6

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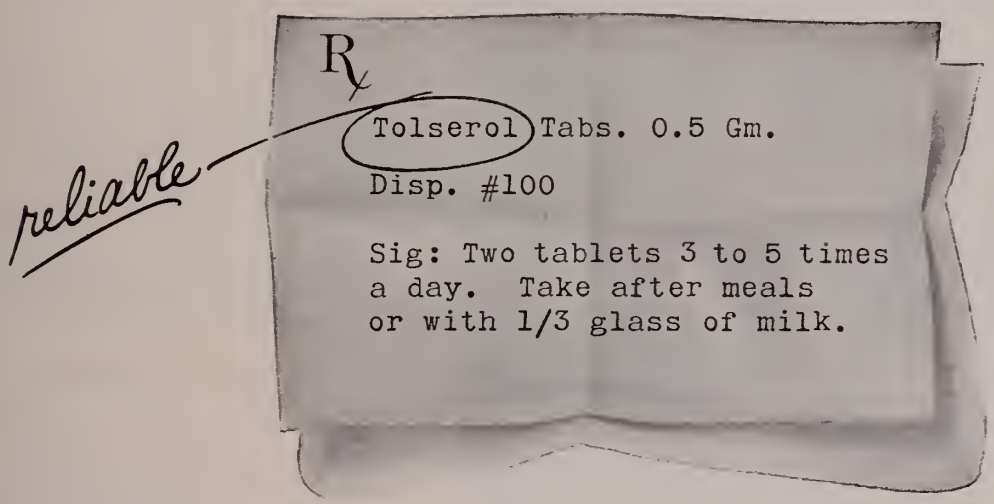
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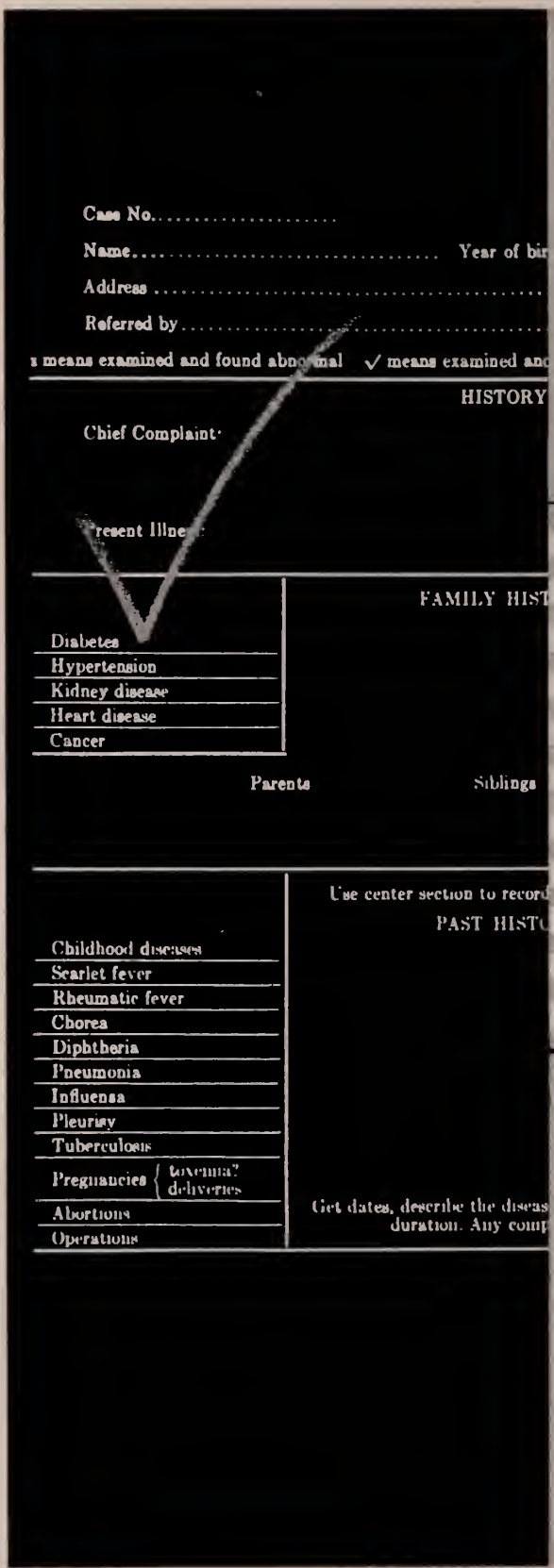
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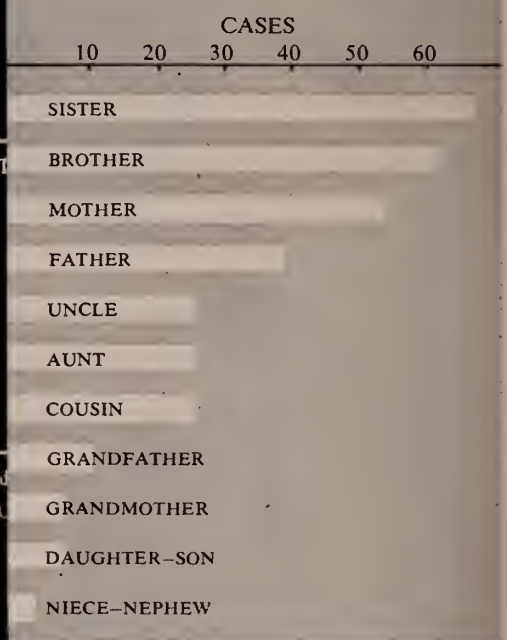
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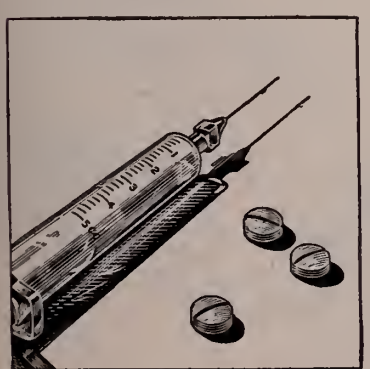
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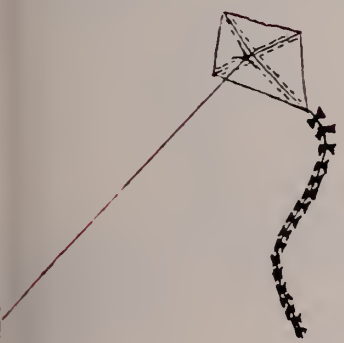
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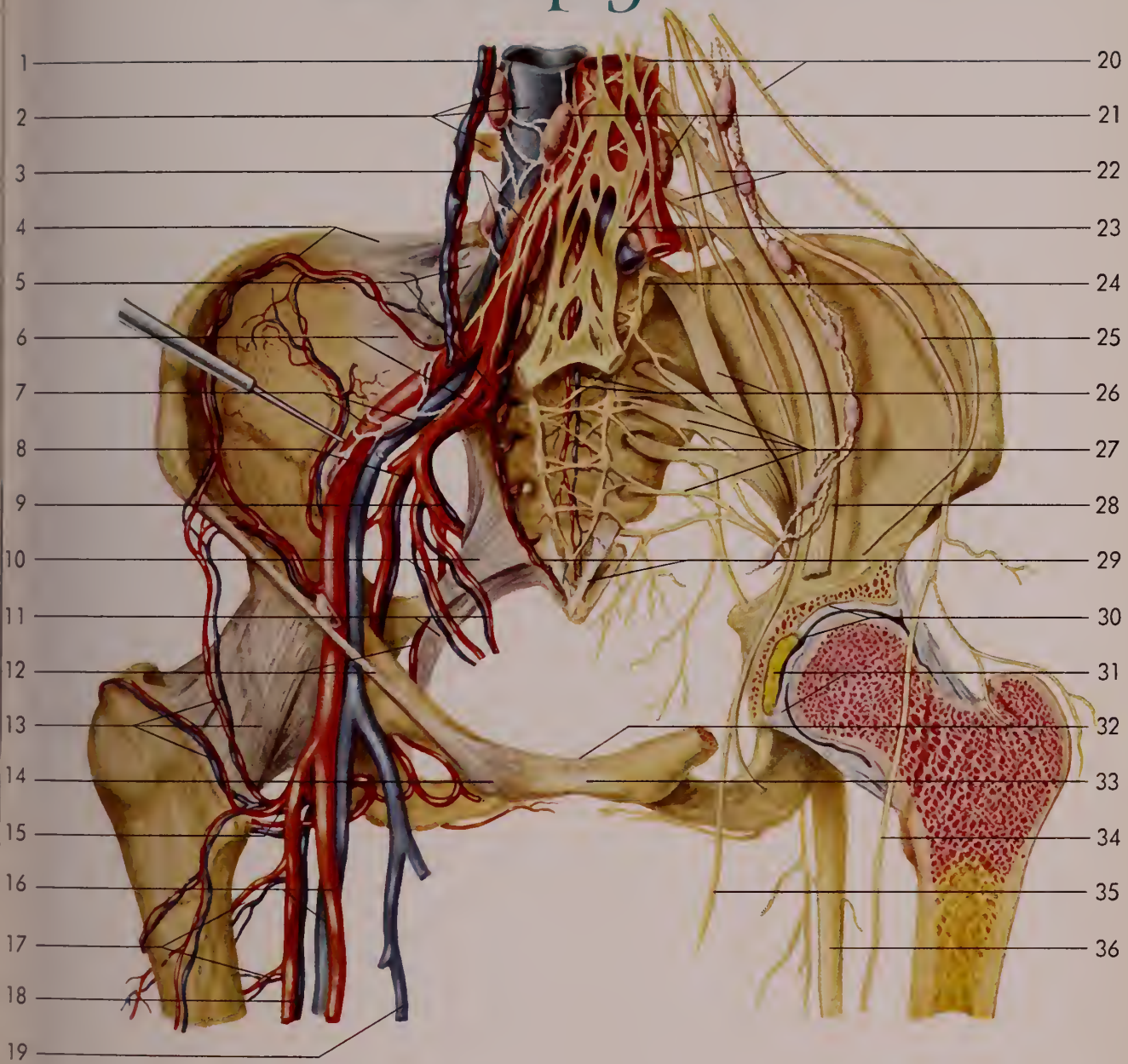
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1 Ovarian artery and vein
2 Vena cava; lumbar lymph nodes
3 Right common iliac artery and vein
4 Iliolumbar ligament; branches of iliolumbar artery and vein
5 Lumbosacral ligament; superior gluteal artery and vein
6 Anterior sacroiliac ligament; internal iliac (hypogastric) artery
7 External iliac artery and vein
8 Obturator artery and vein
9 Inferior gluteal artery and vein
10 Sacrospinous ligament; uterine artery and vein
11 Sacrotuberous ligament; vaginal artery and vein
12 Inguinal ligament; internal pudendal artery
13 Iliofemoral ligament; branches of lateral femoral circumflex artery and vein
14 Lacunar ligament
15 Lateral femoral circumflex artery and vein
16 Femoral artery and vein
17 Perforating arteries and veins
18 Deep femoral artery and vein
19 Great saphenous vein
20 Aorta; ilioinguinal nerve
21 Lateral aortic lymph nodes
22 Lumbar nerves
23 Hypogastric sympathetic plexus
24 Sympathetic trunk
25 Lateral femoral cutaneous nerve
26 Middle sacral artery and vein; lumbosacral trunk
27 Sacral nerves
28 Femoral nerve
29 Lateral sacral artery and vein; anterior sacrococcygeal ligament
30 Lunate articular cartilage; joint cavity
31 Acetabular fat pad; ligamentum teres
32 Interpubic fibrocartilage
33 Superior pubic ligament
34 Anterior branch of lateral femoral cutaneous nerve
35 Obturator nerve
36 Great sciatic nerve

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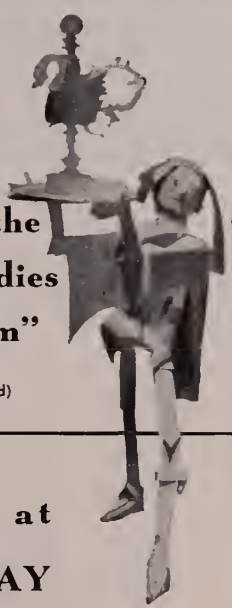
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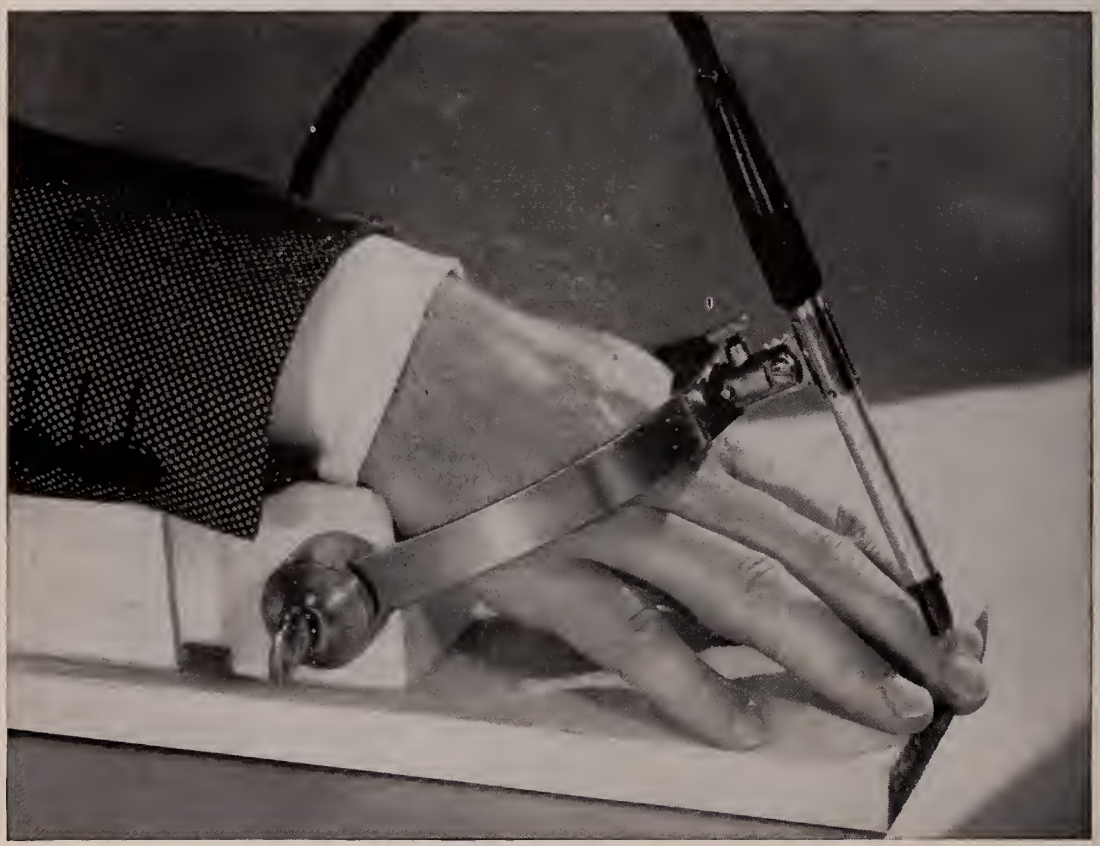


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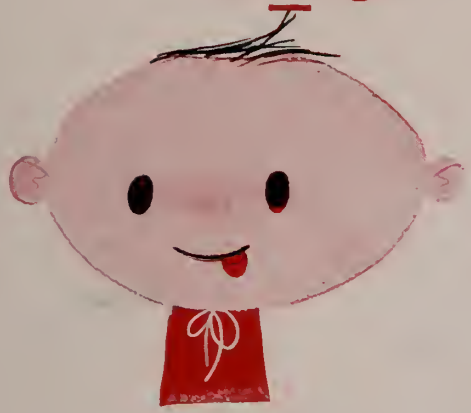
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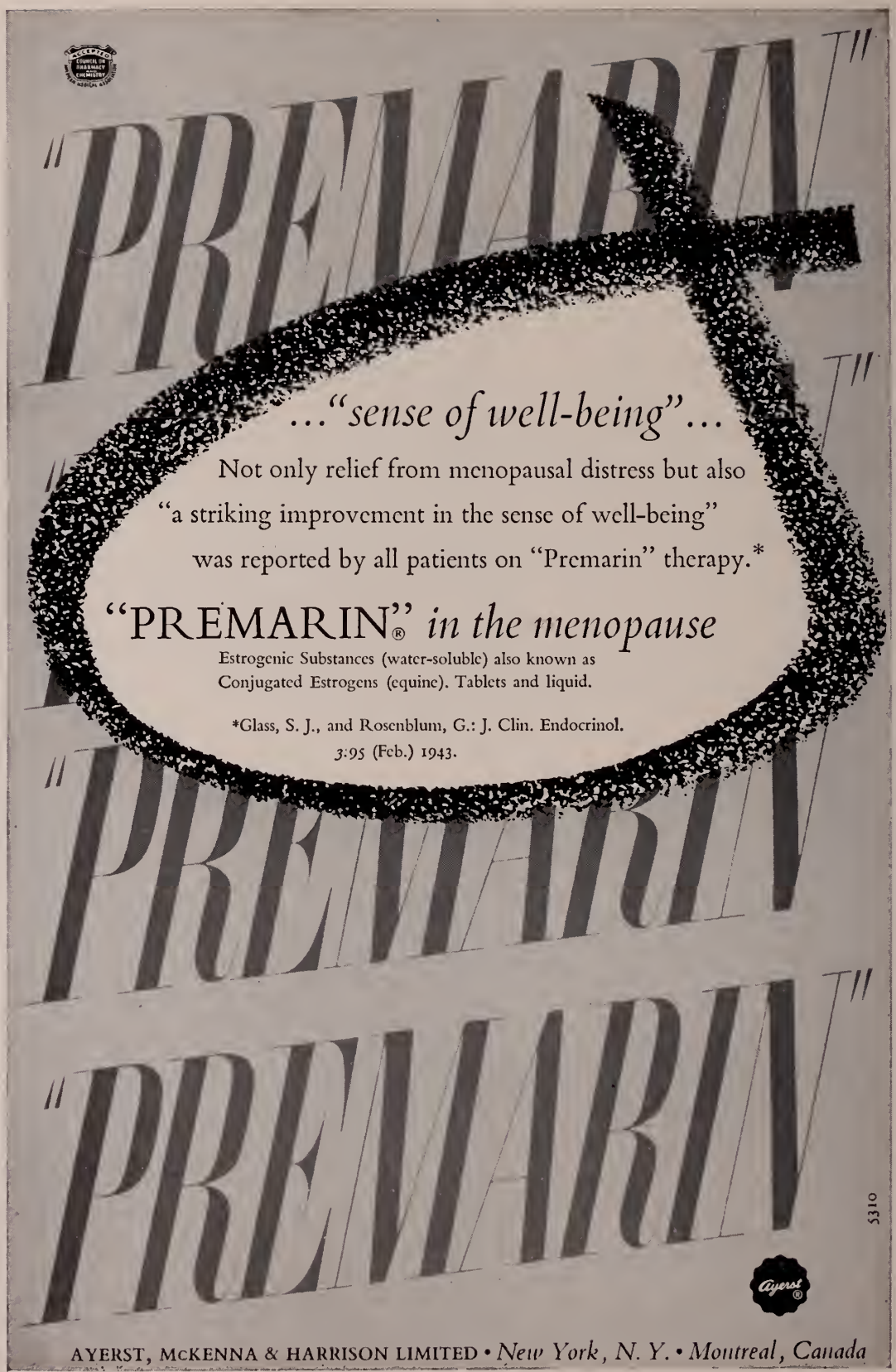
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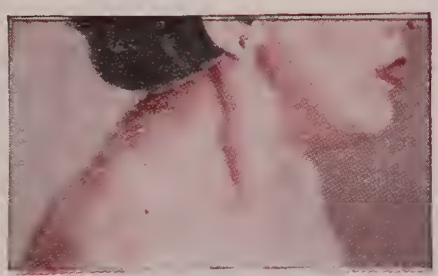
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[1]Evans, R. R., and Rackemann, F. M.: *A.M.A. Arch. Int. Med.* 90:96–127, July 1952.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XL | Jacksonville, Florida, December, 1953 | No. 6

Ultrasonic Therapy: A Review of Its Present Status and Future Possibilities

KENNETH PHILLIPS, M.D.
MIAMI

Sales resistance to change or something new is an inherent characteristic of the human race. The psychology of man is so constructed that his first impulsive reaction to something new is "what's wrong with it?" Clinicians are not exceptional; in fact, they are sometimes dogmatic in opinion regardless of which side of a question they choose. It is, therefore, logical to anticipate that ultrasonic energy will undergo a considerable mental and verbal mauling while it is gaining its birthright.

High frequency sound energy is not new. Wood and Loomis,[1] two American physicists, reported biologic studies with it in 1927. Industrially, ultrasonic energy is being applied with increasing magnitude; but its application to diagnosis and therapy has been slow and comparatively recent. Wide study and reports by recognized scientists in Europe, and those now appearing from American investigators, supply discussions and cases running into thousands, and justify some evaluation and conclusions.

The scope intended here will cover: (1) a brief outline of the clinical physics and technical phases; (2) accepted biologic effects; (3) clinical application and case studies; and (4) impartial discussion with references covering significant phases of the subject.

Physics and Technical Phases

Therapeutic ultrasound waves are a special kind of acoustical energy, much higher in frequency than audible sound. They are produced in, and emitted from, a transducer or soundhead in which is anchored a section of quartz cut in a special way from a large crystal of natural quartz. Quartz possesses piezoelectric qualities when placed in a high frequency electrical field, and in turn emits ultrasonic vibrations from the soundhead. Ultrasonic waves will not travel in air, and can be transmitted only through solid or liquid material, technically called a "coupling." They can be "beamed" although they are not radiation in the sense of x-ray or radium. The energy is not electrical, and not chemical, although it is believed that chemical reactions are accelerated by ultrasonic application.

Soundheads of different instruments may vary in size, shape, crystal dimensions, and the like, but the underlying principle is the same. Actual energy output to the part treated, however, may be different, depending upon the engineering design of the soundhead and crystal dimensions. Instruments used in this work are designed with crystal area of 11.34 sq. cm. and a frequency of 920 kc. pulsed energy. The actual emitting area of the soundhead is somewhat larger, approximately 22.5 cm., with total output from ¼ to 12 acoustic watts of pulsed energy.

Technical application of the transducer is not complicated. Coupling with oil or water between the soundhead and skin is essential since the slightest column of air will prevent transmission of the energy. Extremities and irregular areas lend themselves to treatment under water, during which the face of the soundhead is immersed and kept in motion about 1/2 inch from the skin. Two applications have been advocated, stationery, and movement method. The latter only (slow rotary. stroking) was used in this study.

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 28, 1953.

Biologic Effects

Because ultrasound is a new and different therapeutic energy, one expects variation in opinion relative to its biologic effects. I see no justification, however, for the "alarm reaction" and the brand of "danger" tacked on by a minority group of workers. Certainly it is understood without emphasis that anyone using or working with this energy should be thoroughly grounded in its fundamentals. I have been unable to find any record, written or oral, where, within the intensities prescribed for therapeutic use, anyone has been able to produce tissue destruction without first exceeding the physiologic pain threshold. What other physical modality gives the therapist such a safety valve? Full cognizance is given current experimental work at higher intensities on mice and other anesthetized animals; but to date, in the hands of capable workers, and within the therapeutic dosage advocated by leading authorities, there is no reason for considering ultrasonic energy "dangerous and unsafe." Extensive reports from leading authorities presented at the Third International Medical Ultrasonics Congress at Bad Ischl, Austria, (recently translated in English),[2] and from DeForest, Herrick, Janes and Krusen,[3] Bierman and Licht,[4] and Lehmann and Herrick,[5] who studied effects on tissues in small animals, offer wide information relative to the safety problem.

Many biologic effects of ultrasonic energy are now known. That it offers "good beaming" and "high depth penetration" is apparently accepted. High absorption in muscle as compared to fat gives it advantage over present modalities, and bone can be penetrated. Research opinions differ relative to the thermal element of ultrasonic energy. Schwan and Carstensen,[6] in a brilliant report, evaluate the thermal factor; while European scientists of renown, Van den Bosch,[7] Pohlman, Stuhlfauth, Buchtala, Tschannen and others[8] clearly open the gate for an opinion that heat as such is an indirect, and clinically speaking, probably a minor factor. Zach of Vienna[9] has concentrated a part of his studies on the athermal effects of this energy; and certainly water placed on the soundhead can be vaporized, but the vapor is cold, not hot steam.

Extensive research by Europeans and work in progress by Rosenthal,[10] in New York, on proteins, minerals, fats and sugars, all reveal evidence of biologic effects other than thermal. Intracellular metabolic effects, analgesia, microcellular vibration, action on nervous, blood, and lymph systems have all been included in the biologic survey.

The specific behavior of ultrasonic reflections in relation to density of tissue has initiated studies of this energy as a diagnostic agent. Results at present are empiric.

Clinical and Treatment Application

Many clinical entities have been treated with ultrasonic energy.[2,5,8,10-12] Results reported have varied, but in the over-all have been encouraging. From the vast clinical literature surveyed, a grouping or classification of diseases is difficult. Arbitrarily, however, it is helpful to consider acoustical energy as applied to three large groups: (1) clinical conditions which involve the autonomic nervous system, including peripheral vascular disease; (2) those referable to bone and joints, (arthritides, radiculitis, disks, and acute trauma); and (3) distress and pain syndromes involving bursitis, neuralgias, neuritis, fibrositis, and functional low back distress. Miscellaneous conditions under study, and more specific than this grouping, will not be included in this report.

A definite technic of application and dosage was established from the beginning, and was applied in all cases, regardless of group, with the exception of two rules applied to any individual case. 1. When local distress was manifest, intensity was reduced. 2. In acute conditions, if aggravation resulted, then both intensity and duration of treatment were reduced. Coupling used was either oil or water; only movement or rotary technic was used. Treatment time to each area was eight to 10 minutes daily, or three times or twice weekly, depending upon the severity of the complaint. The total number of treatments varied with clinical response and ranged from three to 15. In arthritis, one third of the treatment was given over the spinal area supplying the nerve roots to the peripheral parts affected, and two thirds to the joint areas themselves.

Cases Studied

The clinical study was carried on in two separate departments with trained operators in each. Individual evaluations were tabulated by operators, then the aggregate surveyed between supervisor and patient, and lastly a final analysis and ratio breakdown of results.

A total of 294 patients have been treated over a period of nine months. Their ages ranged from 14 (only 3 between 14 and 20) to 86 years. The

majority fell between 40 and 65 years. The average number of treatments per patient was eight, significant mostly in justifying therapeutic safety, since in the total of 2,352 treatments given, not one severe local or systemic reaction occurred. There were 123 men and 171 women in the series.

Table 1 summarizes significant clinical data and results. It is recognized that when evaluation of results is dependent upon objective and subjective measurements by both patient and physician, a margin of uncertainty must exist. With the system of independent recheck established, however, it is believed that an accurate trend is shown by the method selected in rating improvement as none, moderate, or good.

General Discussion

Table 1 presents an aggregate picture, the results column of which forms only a part. Challenge on certain points is anticipated, and elaboration is indicated in an attempt to clarify further the table as a whole. The objective of the study and report must be comprehended. The purpose is an attempt to evaluate ultrasonic energy as a new and different therapeutic agent in clinical medicine, and not to test its function against any one specific disease or complaint. This supplied the reason for reporting on only a few cases in certain complaints. A trend toward positive or negative general value is the motive, not specificity. Additional perspective can be gained by closer study of the details given in the table with respect to each group. Certainly from a strict scientific viewpoint, 3 cases of bronchial asthma are meaningless; but when one observes the duration of the complaint together with the fact that all previous therapy including ACTH had failed, the complexion changes. Furthermore, Buchtala, Stuhlfauth, and Sholz[8] have reported favorably on a more extensive study in asthma.

Likewise, in other complaints with reports of only a few cases, the entire table must be studied if the significant trend is to be apprehended. The vascular ulcers, some of five years duration, had all failed to heal, and in all of the cases of gangrene of the foot or toes surgical amputation was indicated when ultrasonic therapy was started. Even in the 1 case in which this therapy was classified as a failure, amputation has not been resorted to over a period of five months, but other emergency measures were instituted and therefore clouded the issue. Study of the age range in the table is significant.

Any criticism for not classifying the arthritic group separately is answered as follows: This was a study in therapy, not etiology. The symptoms demanding relief in this disease are pain, progress of disability, and crippling, regardless of type. The challenge to the therapist is the same in all types, and there is good reason for contending that while we have been spending so much time researching the phases of etiology and types, eight million of these sufferers still remain on the waiting list for symptomatic relief. A first glance at the table revealing 77 failures in 130 cases is not impressive; but further study, showing that in 92 per cent of the total there was complete lack of response to all modern therapy at the outset, again changes the complexion of interpretation. In other words, the hopeless cripple was chosen for the experiment.

In summary, if this study reveals any outstanding value of ultrasonic energy over present established methods of therapy, it would be in acute bursitis, traumatic sprains to joints, and functional low back distress. This statement may bring scientific rebuff from Krusen, Herrick, Lehman and others[3, 5] based on their reports on mice, rabbits and dogs; but clinically these results have been tested and they are sound. Technical and experienced application in these conditions is emphatically important. A current report by Tepperberg and Marjey[13] is interesting.

With specific reference to the intervertebral disk syndrome, it will be noted that none has been treated. The reports, however, of studies by Van Went[2, 14] in Amsterdam, Holland, are of such importance that they are included in the table. Her studies have been wide and deep; and soon, it is hoped, a book under her authorship will be published. Friedland, Bisgrove and Doyle,[15] American pioneers in clinical ultrasonics, treated 29 cases of herniated disk in 1951, with definite relief resulting in only 4 cases. Obviously, their study was during early days, and possibly later studies may be more favorable.

Postulation and prophecy relative to ultrasonic phenomena are, of course, intriguing. The minute sonar "pip" on the screen, which meant so much in submarine location during a critical wartime, may well locate a gallstone in the future. The extensive studies of Travell and Rinzler[16] on trigger areas and the genesis of pain open an additional possibility to ultrasound application.

Table 1. — Summary Picture of Several Diseases Treated with Ultrasonic Energy

Clinical Group	Total Cases	Sex	Age — Range in Years	Duration of Complaint	Previous Therapy	Results		
						None	Moderate	Good
Autonomic nervous system								
Bronchial asthma	3	F-3	17 to 50	8 to 20 years	Conventional, all failures including ACTH	1	1	1
Circulation disorders, legs, skin, ulcers	10	M-4 F-6	61 to 86	6 mos. — 5 yrs.	None, routine, some surgical	2	4	4
Gangrene toes	5	M-2 F-3	39 to 62	3 wks. — 1 yr.	Conventional, all failures	1	1	3
Bones and joints								
Acute trauma: joints, back and fractured ribs	72	M-52 F-20	17 to 46	3 hrs. — 2 wks.	None to usual first aid	8	12	52
Radiculitis	10	M-6 F-4	27 to 42	2 mos. — 6 mos.	Various, including ACTH	4	3	3
Arthritis: rheumatoid, osteo, and mixed types	130	M-38 F-92	41 to 78 Average 55	5 to 40 years	92% failures with modern therapy including cortisone, ACTH and B_{12}	77	38	15
Disk syndrome	0					0	0	0
Disk syndrome, Van Went, Amsterdam, Holland	34	M-10 F-24	18 to 61	Not reported	Not reported	2		32
Pain and distress syndromes								
Acute bursitis	10	M-9 F-1	32 to 51	24 hrs. — 5 days	Injection, heat			10
Chronic bursitis	5	M-4 F-1	27 to 43	1 yr. — 8 yrs.	Various, x-ray, needling	2	3	
Myofibrositis	20	M-11 F-9	31 to 47	2 wks. — 1 yr.	Multiple	5	10	5
Low back distress, functional	22	M-14 F-8	28 to 53	3 hrs. — 1 wk.	Indefinite	4	3	15
Neuralgias, neuritis, herpes zoster	5	M-2 F-3	32 to 55	5 days — 3 yrs.	Indefinite	5		
Multiple sclerosis	2	M-1 F-1	32 to 65	2 — 7 years	Usual routine	2		

Conclusion

Ultrasonic energy, as a therapeutic agent, adds a new modality to present physical equipment.

It has been sufficiently tested to assure its safety, provided its use is by those properly trained in basic fundamentals.

Results of this study, together with voluminous reports from European and American scientists, justify an opinion that this energy offers wide future possibilities.

The most outstanding therapeutic results of this study have been with traumatic injuries, acute bursitis, and low back distress. Other conditions have been discussed.

Studies of ultrasonic energy as a diagnostic agent are empiric, but indicate possibilities of much future value.

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Discussion

Dr. Edward F. Carter, Sr., Tampa: I want to congratulate Dr. Phillips on his excellent paper on a new and controversial subject.

I desire to emphasize two important results obtained from the use of ultrasound. First, there is relief of pain and sedation. Last August I heard Dr. Rosenthal of New York University. He said ultrasound was used in the place of novocain injections for nerve block in a great many cases. Second, it is a great decongestive agent, perhaps the greatest we have had in physical medicine. I used to use the old static machine, which was temperamental and expensive to run, but it was a decongestive agent. Sound wave is easier to use, does not frighten the patient, and does a better job.

Dr. Phillips mentioned first asthma. I have treated a number of patients with asthma with highly satisfactory results, and there is 1 case I want to mention particularly, a case of status asthmaticus. The condition of the patient was desperate. She had spent two months in the hospital in an oxygen tent, had left the hospital against the doctor's orders and had had everything in the line of treatment except cortisone. I immediately prescribed this drug, but it took 200 mg. each 24 hours to make her only fairly comfortable. I decided to use ultrasound on her spine, giving the greater part of the treatment over the stellate ganglion twice a week. She improved rapidly and gained 35 pounds in weight. She looks 30 years younger than she did when I first saw her, breathes with ease and occasionally takes one 25 mg. cortisone tablet a day. She has gone over a week several times, without taking any cortisone whatever and remains perfectly happy.

In circulatory diseases, this modality in my experience has proved most useful. Hematomas, thrombophlebitis, ecchymosis, cellulitis, sprains, sacroiliac and lumbosacral disorders, coxalgia, sciatica, and numerous other muscular and nervous conditions respond well to the proper dosage of ultrasound. I have under my care now a patient with severe Buerger's disease, which has resisted all forms of treatment including two sympathectomies and many nerve blocks. She is seemingly doing well with three treatments a week of ultrasound, six minutes over the fourth lumbar and sacral vertebrae and six minutes over the femoral artery.

Acute bursitis responds well; chronic bursitis is a little more difficult. In the treatment of gastric and duodenal ulcers, some of the reports coming out of Europe seem too good to be true. In some 10 or 12 cases, however, I have found the results most satisfactory. I do not employ this therapy if the ulcer is bleeding, but it is excellent from the psychologic point of view and gives a wonderful sedative effect, relieving gastric distress. Many patients with ulcer will leave off their antacids after meals. One of the reports coming out of Europe claimed 89 cures in 91 cases treated.

Just a few words about intervertebral herniated disks. Dr. Van Went of Amsterdam, Holland recently reported symptomatic cure in 42 cases with ultrasound, but stated that the roentgenogram shows the same prolapse herniation as before treatment, although the patients have no clinical symptoms. It is my opinion that ultrasound in the hands of the intelligent doctor is safe and positive treatment in many of the ills of mankind, and its use and study should be encouraged.

Dr. Samuel B. Kleinman, Miami Beach: As a physician who is particularly interested in physical medicine, I want to thank Dr. Phillips for the efforts he always makes in presenting new and progressive things in our community as well as the state at large. I am particularly grateful as a physician because he always takes the attitude that the patient comes first, and with this new modality, despite all the enthusiastic reports that come from Europe and despite the facilities he has for extending his views, he has been most conservative in applying it to different conditions. I would find it most difficult to discuss every phase of the subject that Dr. Phillips has attempted to cover. In fact, I do not see how he covered as much as he did in the time that was allotted to him, especially with all the references he made to the literature.

In my opinion, the high lights of ultrasonic therapy are two. I am cognizant of the fact that the literature describes a great many fine physical effects from ultrasonic therapy, but in trying this new modality I think there are two phenomena that explain the therapeutic results and they should be employed in its use. First, there is the mechanical effect. This consists of a so-called stirring effect which decreases the diffusion layer at the tissue surfaces; this in turn promotes the absorption and the defusion of metabolites. This phenomenon may well explain a large part of the relief that one gets in traumatic injuries such as sprains and fractured ribs.

The second effect is a thermal effect. Quantitatively,

I would say that this probably is the major effect. The ultrasonic waves heat the tissues at different acoustic impedance levels selectively. In other words, these tissues are all of a different density, and consequently these waves are going to heat them to a different degree. The important feature is that this heating effect cannot be duplicated by any other modality that is now employed. Practically, in applying this modality on the basis of this known effect, it is important that we physicians know how to apply it so that an effective rise of temperature will occur in the tissue we are aiming at. Fortunately, the production of ultrasonic energy for clinical use is so simple that it requires none of us to be physicists; by following directions we can beam to the tissue that requires therapy.

Another important point that Dr. Phillips brought out is that despite the fact that we are dealing with an agent that is potentially harmful, we have a most important safety valve. It consists of the fact that it is virtually impossible for anyone to employ ultrasonic therapy and injure a patient without that patient first experiencing considerable pain. The presence of this pain will preclude further employment of that agent, since the patient will not tolerate it.

With these two effects in mind and with all the basic research that is going on in Europe and in this country, I would say that we have a new modality which permits us to achieve clinical effects that were not possible before. Properly employed, it is a modality that should cause no injury to anyone and permit us to achieve relief in certain conditions which no other modality at present permits us to achieve.

Report of Snake Bites in Florida and Treatment: Venoms and Antivenoms

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Poisonous snakes are still relatively prevalent throughout the state of Florida. Snake venom usually contains two types of toxin in varying proportion from one species to another: a hemotoxin, which produces hemolysis of erythrocytes, extravasation of blood, local destruction of tissue, and extreme edema, and a neurotoxin, which affects principally the respiratory center. Venoms of pit vipers contain more hemotoxin; the venom of the coral snake, more neurotoxin. There are native here all of the four venomous snakes of the United States: the rattlesnake, the moccasin, the copperhead — known as pit vipers — and the coral snake. There is no county of the state which does not have one or all of these species of snakes. The Florida diamondback rattler (Crotalus adamanteus) is one of the largest of the rattlers and is one of the world's most dangerous snakes. The coral snake, while not having the viciousness of the pit viper group, certainly is one of the most deadly of snakes when it does bite.

It has been estimated that the number of poisonous snake bites occurring in the United States per year is between two and three thousand.[1] In the year 1948 one of the authors (CBP), collaborating with Mr. Ross Allen of Silver Springs, was able to collect data on 51 snake bites in Florida. These were cases of which they had personal knowledge or which were reported to them as a matter of interest. It would be reasonable to assume that each year Florida has well over 100 poisonous snake bites, or roughly between 3 and 5 per cent of all bites occurring in the United States.

Although the number of bites is considerable, the emergency nature of the required treatment and the geographic distribution of occurrence make it unlikely in cases of this type that any

Table 1. — Deaths Due to Snake Bites, Florida, 1940-1952*

Year	Total	White	Negro
1952	2	2	0
1951	2	1	1
1950	3	3	0
1949	3	3	0
1948	5	5	0
1947	3	3	0
1946	4	4	0
1945	4	3	1
1944	3	3	0
1943	4	4	0
1942	2	2	0
1941	1	1	0
1940	4	4	0

*Furnished by the Florida State Board of Health, Jacksonville.

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large number of patients would be treated by any one physician or, for that matter, in any one hospital.

It is the purpose of this paper to consolidate data on a statewide report, present a detailed analysis of a specific group of hospitalized cases, report a case, comment on various methods of treatment, and present some chemical and clinical data about antivenom.

The Florida State Board of Health lists 40 deaths resulting from snake bites in a 13 year period, as shown in table 1.

Data obtained from the previously mentioned case histories collected in the year 1948 are shown in table 2.

Table 2. — Review of Data, Poisonous Snake Bites, 1948*

	Rattle-snake	Moc-casin	Coral	Uniden-tified
Number of bites	38	7	2	4
Deaths reported	3	0	0	0
Recovered	29	7	2	4
Outcome not known— probably recovered	6	0	0	0
Cases hospitalized	24	7	2	0
Treatment in physician's office	3	0	0	0
Those known receiving no medical treatment	3	0	0	0
Treatment not recorded	8	—	—	4
Record of receiving antivenom	13	3	2†	0
Use of tourniquet recorded	14	4	1	0
Use of incision or excision recorded	15	4	1	0
Use of suction recorded	14	5	—	0

*From the records of Mr. Ross Allen and Dr. C. B. Pollard.
†Cobra antivenom was received.

Comments on Table 2

The prevalence of bites of the rattlesnake is best explained by his viciousness and his native habitat. He usually is found in territory which woods workers, turpentine workers, field workers, berry pickers, hunters and farmers frequent.

Moccasion bites probably are more frequent than those of the copperhead and coral snake because of the relatively lesser number and narrower geographic distribution of the copperhead and the docile nature of the coral snake.

The 3 deaths shown in table 2 resulted from rattlesnake bites. Two of these were in children: one a 12 year old boy struck by a rattler in the hip, with fang marks 1¼ inches apart; the other a 2 year old baby. These cases substantiate experimental data and many reports in the literature that the lethal effects of a specific amount of venom are proportional to the body weight of the individual.

It is interesting to note that this 12 year old boy was struck in the hip. Fortunately, most snake bites occur in an extremity which can be isolated from the body and main circulation and lymphatics by use of a tourniquet and refrigeration. As bites approach the proximity of the trunk or when they are on the body, face, or neck, certainly the risk increases. The only data on the third death indicate that it was caused by a rattlesnake bite on the hand. Although the patient received early hospital treatment, he died within 24 hours.

In 33 of the 41 reported cases the patient was hospitalized. The use of a tourniquet, incision or excision of the wound, suction, and the use of antivenom have been the accepted routine and order of treatment for several years and have been so carried out in a large percentage of these cases.

Table 3. — Data on Hospital Admissions, Poisonous Snake Bites, Alachua General Hospital, 1945-1952

	Rattle-snake	Moc-casin	Coral	Uniden-tified
Number of cases	8	2	1	3
Deaths	0	0	0	0
Antivenin used	6	2	0	2
Tourniquet used	8	2	0	2
Incision of wounds	7	2	0	2
Suction	6	2	0	1
Antibiotics	5	2	0	0
Tetanus antitoxin or toxoid	1	1	0	1
Refrigeration	3	1	0	1
Transfusion — blood or plasma	1	1	0	0
Evidence of anemia and red blood cell changes	2	1	0	1
Strike in:				
Arm or hand	5	1	1	1
Foot or leg	3	1	0	2
Hot compress	2	0	0	1
Skin necrosis	3	0	0	0
Skin grafts	2	0	0	0
Evidence of secondary infection	2	0	0	0

Source of Hospital Cases Reported

The next group of cases selected for study, numbering 14, was from Alachua General Hospital, Gainesville, during the period from August 1945 through August 1952. Cases in which patients were treated in the emergency room or as outpatients were not included.

Table 5 shows a detailed report of individual cases studied.

Table 4. — Summary of Data on Hospital Admissions, Poisonous Snake Bites, Alachua General Hospital, 1945-1952

Kind of snake:		Pain:	
Rattlesnake	8	None	1
Moccasin	2	Minimal	3
Coral	1	Moderate	5
Unidentified	3	Severe	3
Race:		Extreme	2
White	9	Nausea and vomiting:	
Negro	5	None	11
Sex:		Moderate	2
Male	13	Severe	1
Female	1	Shock:	
		None	6
Age:		Minimal	5
Youngest	3	Moderate	1
Oldest	82	Severe	1
Hospital days:		Extreme	1
Shortest	1	Evidence of infection:	
Longest	86	Absent	11
Average	12+	Present	3
Severity of illness:		Skin grafts:	
No symptoms	1	No grafts	12
Minimal	6	Grafts	2
Moderately serious	5	Exercise a factor:	
Serious	1	No	10
Critical	1	Yes	4

Comments on Tables 3, 4 and 5

Although this is a small series, the rattlesnake is again the predominant offender. There were no copperhead bites. The one coral snake bite was that of a boy who, after stepping on and probably killing the snake, was foolish enough to swing it about in such a fashion that the snake's mouth struck his finger. He complained of a stinging sensation, but there were no demonstrable fang marks. He brought the snake with him, and it was identified as a coral. The boy was admitted overnight for observation. No symptoms developed, and probably no venom was injected.

The race, sex and age are listed only as a matter of interest. The snakes apparently had no choice.

The average of hospital days was greatly increased by case 6 and case 9. In these cases there was extensive necrosis requiring skin grafts. In case 9 the patient's condition was critical. This case presents many interesting factors; it will be discussed as a case history.

The degree of illness of these patients ranged from no symptoms in one instance to critical illness in one.

Pain has always been mentioned as one of the outstanding symptoms of pit viper bites. It is interesting to note that in this series of cases the severity of pain was variable and not directly related to the seriousness of the illness. Personal talks with Mr. Ross Allen, who has himself experienced 10 venomous snake bites, bring out the fact that the pain, though always present to some degree, is a most variable factor. Mr. Allen thinks that the time he was most seriously ill as the result of a snake bite the amount of venom was so great and the venom so potent that it caused an almost immediate numbing; the severe pain came secondarily several hours later. The history of pain in case 9 is similar.

All antivenom used was standard — Antivenin (Nearctic Crotalidae) Polyvalent (North American Antisnakebite Serum) Wyeth. The amount used varied from 1 ampule to 5. In the rattlesnake bite cases all patients except those in cases 1 and 6 received antivenom. It is noteworthy that in both of these there was a degree of skin necrosis. Antivenom was used in both cases of moccasin bite and in two of the unidentified group. The value of antivenom is no longer questioned; the amount and method of use are to be determined for the individual case.

At the present writing no commercial antivenom with high enough antineurotoxic titer to furnish adequate protection against coral venom is available.

Two of the patients who experienced nausea and vomiting had received antivenom. It is questionable whether these symptoms resulted from the venom or the antivenom.

The existence and degree of shock paralleled the severity of illness.

Infection was present as a factor in 3 cases. In cases 6 and 9 there was definite skin necrosis with secondary infection. In case 3 it was questionable whether or not the infection resulted from the wound incisions.

In cases 5, 6, 7 and 9, exercise of that part of the body receiving the bite was probably a factor in the severity of the illness. All of the patients in these cases were struck in the lower extremity. Each walked a considerable distance following the snake bite; the patient in case 5 walked as far as 6 miles.

The manner and time of applying tourniquets were variable as were the length of time used and the method of release.

The incised fang wounds and other incisions made in this series of cases varied from one with a minor scratch to one with extensive incisions over the lower extremity which required considerably more time healing than would have the original snake bite.

There was no record of the use of an alcoholic beverage as an antidote in this series of cases.

Table 5. — Individual Case Studies of Data on Hospital Admissions, Poisonous Snake Bites, Alachua General Hospital, 1945-1952

Case Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Kind of snake*	R	R	R	U	M	R	U	C	R	R	R	U	R	M
Race	W	W	W	N	N	N	W	N	W	N	W	W	W	W
Sex	M	M	M	M	M	F	M	M	M	M	M	M	M	M
Age	8	33	27	82	39	3	23	17	44	63	19	28	9	24
Hospital days	7	1	3	3	3	42	4	1	86	9	2	3	25	3
Severity of illness	++	+	+	+	+++	++	++	0	++++	+	+	+	++	++
Pain	++	++	+	++++	++++	++	++	0	+++	+++	+	+	++	+++
Nausea and vomiting	++	0	0	0	++	0	0	0	+++	0	0	0	0	0
Shock	+	0	0	0	+++	++	+	0	+++	0	0	+	+	+
Infection	0	0	++	0	0	+++	0	0	+++	0	0	0	0	0
Skin grafts	No	No	No	No	No	Yes	No	No	Yes	No	No	No	No	No
Exercise a factor	0	0	0	0	+++	++	+	0	++	0	0	0	0	0

*R, rattlesnake; U, unidentified; C, coral; M, moccasin.

In 9 of the 14 cases rubber cup suction was used, preceded in approximately half the cases by mouth suction.

Antibiotics used in this series were all some form of penicillin; they were used in one half of the cases.

Tetanus antitoxin, toxoid, or combined tetanus-gas gangrene antitoxin was used in 3 cases.

Some type of refrigeration or cooling of the extremity was used in the most recent cases.

Red blood cell changes, as indicated by anemia, decreased hemoglobin, evidence of anisocytosis and hypochromia, or the presence of target cells, were demonstrated in 4 of these cases.

All of the bites were on an extremity; this may be a factor in accounting for the lack of fatalities.

Hot compresses were used in some of the earlier cases.

Report of Case

Case 9. — The following is a verbatim history given by Mr. G. R. of his experiences in connection with a snake bite suffered on July 2, 1951:

"This happened on the second day of July. I had just looked at my watch, and it was six minutes till six o'clock. My three little boys were helping me pick blueberries. One was right with me, and the other two were about 30 yards away in the truck. We had been picking in the bushes all evening and looking before we stepped. I said to one of the boys, 'Let's pick this little wad of berries before we go home.' The other two boys were worn out.

"I put my left foot between me and the boy, my oldest boy, without looking. When I put it down, something struck me in the leg. When I looked, there was a hole about as large as the end of my little finger on my left ankle, on the outside. Blood was spurting out. I looked down and saw the snake with his head lying in the center of the coil, ready to strike again. About that time everything turned yellow to me, just as yellow as anything you ever seen. I told the boy to get back, that there was a big snake there. He screamed and ran. When he screamed, I pulled my foot back and went away about three steps, then turned and went back to kill the snake with my pistol. I almost put my foot on him again. I shot him three times with my .32 Special pistol.

"I walked a few steps away to a little road, sat down, rolled my pants up to keep the blood off, corded my knee and called the oldest boy. I gave him my knife and told him to cut a cross over the bite. He screamed all the time like something was killing him, but he cut it and he did a good job. We started to town then to try to get some help. I drove my truck about 6 miles to town [Trenton]. Everything still looked yellow until I got to Williston to the doctor. In two minutes after the snake bit me my throat was perfectly dry, and my nose felt like it was four inches across. I couldn't spit, but I didn't want anything to drink either. The wound felt just about like a stick had stuck in my leg. As soon as I got to Trenton I got the undertaker, Mr. Dobbins, to take me to Williston. The doctor and the drug store in Trenton didn't have any serum for treating me.

"The first pain I felt was just before we got to Williston. It was the awfulest pain I ever felt and it was in the calf of my left leg, just above the snake bite, and kept coming up and up. Just as they carried me in the doctor's office at Williston it cleared my left hip. Mr. Dobbins, the undertaker, said I turned dark.

Table 6. — Blood and Transfusion Data, Serious Rattlesnake Bite

	Hospital Day						Hospital Week						
	1st	2nd	3rd	4th	6th	8th	14th	3rd	4th	6th	7th	8th	9th	10th	11th	12th	13th
Red blood cell count	5.0	3.7	3.9		2.4	4.1	3.5	3.3	3.7	3.0	3.4						
Hemoglobin	15.1	11.6	12		6.5	9.8	8.3	8.8	10.1	9.2	7.8	10.5	9.2			9.6	
Hematocrit reading		40				33											
Evidence of red cell changes	0				+++	++	++	++	+	+	++						
White blood cell count	16.5				21.5	15.1	22.5	9.7	6.8		10.2						
Plasma transfusions (number)		8	1	2			1				2						
Whole blood transfusions, 500 cc. each (number)					1	2	1	1		1	2	1		1	1		1

Total Transfusions:
Plasma 14
Whole blood 12

"Dr. Vinson, at Williston, gave me a shot for my heart just as soon as I got in his office, and that stopped the pain suddenly. The first thing he did after giving me the shot was put a suction cup on the wound. Then he gave me shots from my shoulders to my toes. After he had worked with me for a while, he insisted that I come to Gainesville for a couple of days. I insisted on staying with him, but he said he didn't have room and besides he was a little scared. The same undertaker brought me to Gainesville, and Dr. Vinson sent a note to Dr. McClamroch telling him what he had done for me. Before I left his office, his nurse called Gainesville and told them I was on the way, that I had had a snake bite and to be prepared for me. When I got here [Alachua General Hospital], they took me in the operating room and took my clothes off and put a shirt on me and a sheet over me. They cut two holes in my leg just above my knee and worked suction cups on them for a while. They gave me some shots and brought me upstairs.

"The further I went the worse my mind got until it went blank. About the fifth day after I came here, my leg split all the way down in the back; after that I came back to my right mind and started getting better. I've been getting better ever since."

This 44 year old white man was admitted to the Alachua General Hospital at 7:30 p.m. on July 2, 1951, one and one-half hours following the snake bite. He was mentally clear and cooperative, and complained of severe pain in his left leg and nausea; he vomited several times.

Table 7. — Additional Laboratory Data

1st day	Blood Kahn: Negative Urine:
2-22nd days	a. Albuminuria persistent in varying degree
4th day	b. Bile negative; urobilinogen negative Smear from snake bite wound: No organisms seen Culture from snake bite wound: Proteus mirabilis isolated
7th day	Nonprotein nitrogen: 45.5 mg.%
8th day	Platelet count: 206,580 Clotting time: 3.5 min. Bleeding time: 2 min. Sedimentation time: 26 mm., 1 hr. V.P.C. = 32 vol.% C.S.R. = 4 mm. Icterus index: 11.2 units Serum bilirubin: Total bilirubin = 1.5 mg.% Direct reading = 0.9 mg.% Prothrombin time: 100% plasma (15"-20") = 75% of normal 12.5% plasma = patient over 6 min.
9th day	100% plasma (14"-19") = 74% of normal 75% plasma (17"-23") = 74% of normal 50% plasma (20"-26") = 77% of normal 25% plasma (27"-35") = 77% of normal 12.5% plasma (40"-70") = 57% of normal Coagulation time (Lee-White): Normal control = 5 min. Patient = 5 min.
16th day	Red cell fragility: Control, hemolysis begins .42% NaCl; Complete, .36% NaCl Patient, hemolysis begins .42% NaCl; Complete, .30% NaCl



Fig. 1.— Skin necrosis following rattlesnake bite prior to skin graft.

(Courtesy, Mr. J. M. Bonnell.)

The blood pressure was 140/90; the pulse rate was 132 and regular. Physical examination gave essentially negative results except for the left leg; there was slight edema of the foot, no discoloration, and an incised wound 4 or 5 cm. in length just above the external malleolus through the thickness of the skin. Only one fang had struck the patient.

Prior to his arrival, he had received at a physician's office 2 ampules of antivenom and ¼ grain of morphine and suctions by means of rubber suction cups. Also, the tourniquet had been shifted from midcalf to low thigh level.

He was given 2 more ampules of antivenom, ½ ampule in the area of the wound. The wound was cleansed and suction applied by means of rubber cups for a period of approximately one hour.

The tourniquet was released at 15 minute intervals for one minute and removed entirely at 12:30 a.m., or six and one-half hours after he was struck.

He was given combined tetanus-gas gangrene antitoxin; penicillin was started and Cortone, 50 mg. every six hours.

Eight hours following injury, the blood pressure began falling, and the pulse became more rapid and weaker. He remained in a moderate degree of shock for about 12 hours, after which he felt better and the blood pressure had now risen to 118/64. By this time considerable discoloration of the foot, leg and thigh was developing, with some edema. Another ampule of antivenom was given.

At the end of 24 hours he looked well. He had received 5 ampules of antivenom, 2 units of plasma, and 2,000 cc. of 5 per cent intravenous glucose. Severe shock then developed, he became pulseless, and no blood pressure was obtainable. He was placed in an oxygen tent, and more plasma was given (8 units during the second day).

During the third day his general condition improved; his leg, however, looked progressively worse. A mottled purple discoloration and edema had gradually spread from the lower leg to the upper thigh, groin and abdomen.

The fourth day he again had a moderate degree of shock, which responded well to plasma transfusions. By this time the discoloration had spread as high as the thorax and was evident on both sides of the chest wall, more so on the side opposite to the bite. His general condition seemed fair, but a considerable degree of scrotal edema and of abdominal distention was developing. Frequent doses of morphine were required for pain.

By the sixth day examination of the blood showed a decided drop in red blood cells and hemoglobin with great changes in the red blood cells, notably anisocytosis, hypochromia, occasional target cells, and rare nucleated red blood cells. Whole blood transfusions were started.

By the tenth day he was fairly well stabilized, but continued to run a febrile course. The edema and mottling were subsiding, and tissue necrosis was developing over the posterior portion of the leg and thigh (fig. 1).

The daily temperature varied from 99.6 to 103 F. during his 86 day hospital stay; the pulse rate, from 110 to 130.

Great necrosis of the calf and posterior surface of the thigh developed with secondary infection. These areas were debrided and grafted; takes were rather poor, and the wound was allowed to heal by granulation.

At the time of his discharge, the wound was still unhealed; the patient was bedridden and still febrile.

Tables 6 and 7 show blood, transfusion, and other laboratory data.

A follow-up check revealed that the patient ran a febrile course about 10 days after discharge from the hospital; he was weight-bearing in about two months; and his wounds were covered with skin in about four months. He was able to resume light work in about six months. He is still unable after one and one-half years to do the heavy farm work he did prior to his snake bite because of pain in the leg and swelling on periods of standing, tiredness, and a limp.

Treatment

Since in most cases of snake bite the patient will first be seen and treated by nonmedical personnel, two phases of treatment will be considered:

1. Immediate, or first aid treatment
2. Subsequent medical or hospital treatment

First Aid Treatment. — All persons who are in danger of being snakebitten and those who might be expected to render first aid treatment should have a clearcut understanding of the proper procedures to follow.

Identification of the snake with a reasonable degree of certainty is most important. Treatment of venomous snake bites is not without some hazard. Unnecessary treatment, in addition to being useless and dangerous, causes needless apprehension, hospitalization and expense.

Firm, early application of a tourniquet at the nearest one bone level between the bite and the body is recommended: in the case of a finger or toe, at the base of the digit; in the case of the hand or forearm, the midupper arm; in the case of the foot or leg, the lower thigh. In cases of bites above the knee or elbow, the tourniquet necessarily will be proximal to the bite. The tourniquet must consist of material at hand, preferably some elastic material. If possible those at the arm or thigh level should have a protective layer beneath. The tourniquet should be applied tightly and released at 15 minute intervals for a period of about one minute.

Some controversy exists regarding the advisability of incision of these wounds; one recent article advocated the discontinuance of cut and suction.[2] For the time being when one is dealing with the Florida variety of venomous snakes, it would seem wiser to continue use of incision and suction. In considering incisions of the fang marks for the purpose of removal of venom, one should remember that the fangs of all pit vipers are curved, and with the snake always striking in a downward stroke the venom would not be injected immediately under the fang marks but, rather, backward in the line of the snake's body at the time he struck. The incisions should be made starting at the site of the fang marks and extending backward at a depth and length comparable to the size of the snake and the strength with which he struck. The value of multiple incisions proximal to the site of injury is doubtful and certainly not advisable as a first aid procedure. Underlying structures must be borne in mind.

Suction by mouth seems to be a natural reaction and is a safe procedure in the absence of cuts and abrasions in the mouth. Since the venom is rapidly absorbed and removal of a portion of it by suction can be accomplished, this seems a valuable procedure. There are available several devices for the purpose of suction. Experience in these cases has been limited to the use of the variable-sized rubber suction cups so made as to fit onto the fingers or toes satisfactorily.

Antivenom, if available, should be used immediately following tourniquet, cut and suction, or if possible, at the same time these procedures are being carried out. If not available at that time, it should be used as soon as possible. People carrying antivenom or those apt to use it should familiarize themselves with use of the special syringe by reading the instructions enclosed in the package.

Exercise or use of the struck part, particularly if an extremity, definitely increases the absorption of the venom. If possible, that part of the body should be given immediate and complete rest.

Transportation of the patient to the nearest available adequate medical facilities should be planned in such a manner that the patient reaches his destination in the least time with minimal exertion.

Whisky and other alcoholic beverages have no useful place in the treatment of snake bites and may be detrimental.

Cooling or refrigeration of the extremity at the earliest possible time is valuable in reducing the absorption of the venom and in reducing the pain. When it is rendered as a first aid measure, any means at hand is satisfactory, such as ice water, cracked ice, or ice cubes. This does not replace tourniquet, incisions and suction; they may be carried out simultaneously. Several favorable references to some type of cooling or refrigeration of venomous bites have appeared in the literature recently.[2-4]

Medical and Hospital Treatment. — In all cases of venomous snake bites of any consequence the patient should be hospitalized. The number of cases would be a small part of the total num-

ber of hospital admissions, but the nature of the illness and the importance of early method of handling make it desirable that the hospital personnel likely to be caring for these cases have a basic understanding of the rationale of treatment of venomous bites.

A rapid evaluation of previously rendered treatment, inspection of the wound, consideration of the time factor, and the type and size of the snake will be important in determining if further incisions, suction, or tourniquet is required. A change of position and type of tourniquet is often desirable at this time.

Accurate time limits on tourniquet removal depend on the method of use: tightness, periods of release, and material used. Certainly, in order to prevent complication, it would be desirable to have all constrictions removed at the end of a two hour period. In cases in which refrigeration or cooling is used, tourniquets may be removed earlier with greater safety.

Refrigeration or cooling, which has been used in recent cases, has seemed beneficial. The method of use should be determined by the means at hand. Direct application of ice or ice water should be limited to immediate chilling and should be followed by multiple ice bags surrounding the extremity protected by toweling. The time of removal is questionable; in this series all ice bags were removed between the second and fifth days.

Early blood level determinations are desirable in order better to evaluate subsequent changes.

Routine use of tetanus antitoxin or toxoid, as indicated, would seem just as desirable here as in any other puncture wound.

Antihistamines are indicated since the venom of these snakes releases histamine from the tissue.

The use of blood and plasma is to be determined by individual needs.

Venoms and Antivenoms

Although thousands of publications on animal venoms[5] have appeared, little specific information regarding toxicity and chemical composition of these poisons is available.

Analyses of various venoms show the presence of carbon, hydrogen, nitrogen, and sulfur in varying amounts. While the structures of the components of venoms have not been established, toxic effects have been attributed to the presence of proteolytic enzymes, phosphatidases, and neurotoxins. Porges[1] recently gave a most interesting discussion of the biochemistry and mode of action of snake venoms.

In the United States we are primarily interested in treating cases resulting from the bites of native poisonous snakes. The Antivenin (polyvalent) which is employed for treatment is prepared by injecting a mixture of the venoms shown in table 8 into horses. Small doses are administered until the animals become hyperimmunized. Each horse then receives 3,750 mg. of the venom mixture shown in table 8, given in three weekly doses of 1,250 mg. each. After a rest of 10 days the animal is subjected to a double bleeding with two days of rest between the first and second bleeding. The horse is then allowed to rest for 30 days, after which the cycle is repeated. Antivenin is processed from the withdrawn blood.

Table 8. — Amounts of Each Venom per Horse for a Three Injection Cycle Prior to Each Double Bleeding (Hyperimmunized Animals)

Crotalus atrox (western diamondback), U.S.A.	625 mg.
Crotalus adamanteus (eastern diamondback), U.S.A.	625 mg.
Crotalus terrificus (tropical rattlesnake), S. Am.	1,250 mg.
Bothrops atrox (fer-de-lance), S. Am.	625 mg.
Bothrops neuwiedii, S. Am.	625 mg.

Research studies have involved various combinations of different venoms in producing antivenoms. Neutralization tests show that the antivenom produced from the venom mixture shown in table 8 has a broader polyvalency against the venoms of North American snakes, with the possible exception of the coral snake, than antivenom produced from any other venom combination studied.

Many of the horses under constant immunization and bleeding survive from seven to eight years. Pathologic studies of the tissues of these horses have not been made although they might furnish valuable information.

Although some persons are opposed to the use of antivenom, its value when administered early in the treatment of snake bite has been demonstrated in many cases.

A pool of recent horse serum bleedings gave the mouse neutralization titers shown in table 9.

The titer of Antivenin against Crotalus terrificus venom is $75 \times LD_{50}$; this venom is considered neurotoxic in nature. Regardless of these facts, the titers of Antivenin against such neurotoxic venoms as cobra and coral are definitely low. The value of Antivenin for treatment in cobra or coral snake bite cases is indeed questionable.

Table 9. — Titers Based upon LD_{50} of Venom Neutralized per Cubic Centimeter of Antivenin Injected Intravenously into 18 g. Mice

Venom	Titer of Antivenin
Crotalus atrox	16 x LD_{50}
Crotalus terrificus	75 x LD_{50}
Crotalus adamanteus	39.6 x LD_{50}*
Bothrops atrox	75.6 x LD_{50}
Bothrops neuwiedii	44 x LD_{50}*

*Approximate

Many variable factors must be considered in snake bite cases. One of these factors which is especially significant is the variation of the toxicity of venom from individual snakes of uniform size of the same species. Recently toxicity and stability studies on dried cottonmouth moccasin venom were reported.[6] Each sample studied represented the pooled venom from 14 to 18 moccasins of uniform size. Table 10 shows that the initial LD_{50} values of the pooled samples varied from 29 to 46.[6] Variations in toxicity undoubtedly occur in venoms from other poisonous snakes. Obviously this variation is an undeterminable but important phase of each snake bite case.

Table 10. — Data Concerning the Toxicity and Stability of Moccasin (Agkistrodon Piscivorus) Venom

Sample No.	LD_{50}*				
	Initial	After Storage for			
		6 months	12 months	18 months	24 months
1	29	31	35	35	35
2	28	32	33	31	30
3	36	34	42	37	38
4	41	38	41	39	40
5	45	44	44	45	44
6	42	45	53	44	46
7	39	37	41	39	41
8	38	43	50	42	41
9	34	38	36	40	36
10	29	34	35	32	32
11	45	42	49	52	50

*LD_{50} in mg./kg. white rats.

Various venoms have been reported to produce liberation of histamine[1, 7, 8] from tissues in snake bite cases. In 2 serious cases recently observed, the patients experienced intense itching. This condition was controlled by administration of an antihistamine (Benadryl).

The destruction of tissue in the area of venom injection has been attributed to enzymes in the venoms.[7, 9, 10] The speed of chemical reactions is decreased by lowering temperature. It is interesting to note that in recent cases in which refrigeration was employed and Antivenin administered, the patients experienced minimal tissue necrosis.

In 2 serious cases resulting from eastern diamondback rattlesnake bites the site of venom injection into the two patients was approximately the same. In each case the area of the bite was quickly excised, and each patient received Antivenin. Refrigeration was employed in one case, and no destruction of tissue resulted. In the other case, without refrigeration, considerable damage resulted around the excised area.

Summary and Comments

Studies involved in this paper indicate: (1) prevalence of rattlesnake bites; (2) value of proper first aid and early hospital treatment; (3) probable value of refrigeration; (4) value of antivenom in pit viper bites; (5) questionable value of antivenom in coral snake bites; (6) desirability of blood studies; (7) importance of early identification of the snake; (8) variation in titer of antivenom against various venoms; (9) variations in toxicity of moccasin venom, and (10) low titer of antivenom against coral venom.

The field of venoms and antivenoms presents a research challenge to the various branches of medical science. It is hoped that additional research in blood studies, serology, pathology and chemistry in relation to venoms will be stimulated.

The authors express their appreciation to Dr. B. Scott Fritz and Mrs. Eleanor E. Buckley of Wyeth Laboratories, Inc., for their cooperation in supplying technical data regarding Antivenin and certain venoms.

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Dr. Andrews, concluding: In summary, I would emphasize the value of first aid and early hospital treatment. Therapeutic measures are tourniquet, incision, suction, antivenom and refrigeration in the order named, and if possible the cooling first if they are carried out simultaneously. Refrigeration appears to be valuable and it certainly deserves further trial. The value of antivenom in pit viper bites is indisputable in my opinion. Its value, however, in coral snake bites is questionable. The desirability of blood studies and the importance of early identification of the snake are obvious. That treatment itself is dangerous is to be remembered; let us not use it if we do not have to resort to it. Variations in toxicity of the moccasin venom and the low titer of antivenom against coral venom were brought out by Dr. Pollard.

The Management of Hypertension

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As bacterial infections have come increasingly under control with the development of antibiotics, hypertension and arteriosclerosis have become the major causes of disablement and death, especially after middle age. The confusion that used to exist between nephritis and essential hypertension has been clarified as a result of the work of Volhard[1] in Germany and Ellis's school at the London Hospital.

The Pathogenesis of Hypertension

In spite of an immense volume of research on blood pressure regulation since Ludwig invented the kymograph in 1847, physicians still do not know what causes a sustained elevation of blood pressure. Many reflex influences, endocrine substances and pharmacologic agents are known which will cause transient alterations of blood pressure. Little, however, is known about sustained hypertension except its close connection in some cases with kidney disorder. Diminution of the caliber of the renal artery leads to the production of renin,[2] but apart from this positive role of the kidney in producing a pressor substance, it is also possible that the kidney normally eliminates a pressor substance formed elsewhere in the body, for in nephrectomized animals kept alive by various means hypertension may develop.[3]

Attention recently has been focused on the suprarenal cortex. Desoxycorticosterone acetate in excess can induce hypertension while a salt-free diet (for example, rice) will bring the pressure down. Some forms of experimental hypertension depend on intact suprarenal glands.[4, 5] Hypertension in pregnancy (pre-eclamptic toxemia) may be a forewarning of the development of essential hypertension in later years. The close association of hypertension, arteriosclerosis and diabetes is well known. In patients with these disorders the high blood pressure per se seldom becomes severe, but the associated arteriosclerosis is often severe and plays an important part in the final breakdown. The part played by stress and worry is difficult to evaluate, but hypertension has developed in rats exposed to the continually recurrent blast of a klaxon horn.[6] It is certainly true that emotion raises the cardiac output, but stimulation of sinoaortic reflexes causes the arterioles to dilate, thus preventing any rise in blood pressure. Volhard[1] thought that these reflexes ultimately become exhausted so that the blood pressure rises during emotion. This state would lead finally to anatomic thickening of the arterioles, which would perpetuate increased arteriolar resistance and make hypertension permanent. It is now known that arterial pressure can always be reduced to normal by powerful vasodilator substances, even in the last stages. Anatomic obstruction of arterioles is therefore not an important factor in hypertension. Neurogenic factors, however, are probably more important than formerly thought.

Recognition and Causal Analysis of Hypertension

Hypertension is diagnosed when the diastolic pressure in an adult is over 90 mm. Hg. Technical errors may arise from small or loose sphygmomanometer cuffs, especially in fat arms. The expanding rubber bag must compress the artery before the elastic limits of the bag are reached.

When the diagnosis has been made, the next decision is whether or not the hypertension is

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secondary to some other cause amenable to treatment. Such causes include coarctation of the aorta, unilateral kidney disease and pheochromocytoma. Attacks of failure of the left side of the heart (for example, aortic stenosis) may be associated with an acute rise in pressure (Stauungshochdruck) which disappears when the heart failure is brought under control. Acute nephritis similarly causes temporary hypertension. Chronic nephritis and congenital cystic kidney also in like manner produce high blood pressure. Cushing's syndrome is perhaps less common than pseudo Cushing's syndrome,[7] in which hypertension occurs in obese plethoric young subjects. Platt[8] emphasized the rarity of essential hypertension under the age of 40. It is of particular importance that, under this age, hypertension should be regarded as secondary until all possible etiologic factors have been excluded.

Hypertension due to unilateral kidney disease can often be effectively treated by surgical means.[9, 10] Malignant hypertension may even be reversed.

Excision of coarctation of the aorta is not necessarily followed by reduction of blood pressure to normal levels. Factors are involved other than mere local obstruction. Successful excision of pheochromocytoma probably yields the most satisfactory operative cures, but the disorder is an uncommon one.

Essential Hypertension

In ascending order of gravity essential hypertension may be:

1. Intermittent, rising during periods of nervousness or emotion and settling to normal with rest and reassurance. A majority of the subjects with this type of hypertension become more persistently hypertensive later.[11]

2. Remittent, subsiding to a lower level with rest and sleep.

3. Sustained, though continuing to show fluctuations. This stage may remain

   (1) Uncomplicated for many years, but sooner or later important organs become involved, notably the brain, eye and heart. Severe and disabling headaches should be included as meningovascular complications. This stage can be called

   (2) Sustained complicated hypertension.

4. Premalignant. There are signs of accelerated tempo of development of cardiac, retinal and cerebral vascular complications. Diastolic pressure is above 120. The course of the illness is rapid, terminating in two to three years.

5. Malignant, with papilledema and progressive kidney involvement in addition to other features at the premalignant phase. Diastolic pressure is usually above 140. The illness usually terminates in a few months.

Assessment of Prognosis

Eyeground changes give valuable prognostic implications.[12] The height of the blood pressure is important in young subjects, but after the age of 60 excessively high pressures may be encountered with good prognosis and little retinitis. Blood and Perera[13] noted survival for 10 years or more in 20 patients with diastolic pressures of 120 plus and even with retinitis at the beginning of this period. Rarely malignant hypertensive retinopathy and neuroretinopathy may regress spontaneously with survival a year or two beyond the expected time.

Treatment

Blood pressure is difficult to reduce, and the most effective remedies at the moment have their unpleasant side effects. For this reason I do not undertake a hypotensive regimen in groups 1 and 2. Treatment is only instituted when hypertension has become complicated, malignant or premalignant. Reduction of pressure cannot abolish atherosclerosis or other disease of the vessel wall which predisposes to thrombotic or hemorrhagic complications. Pressure reduction, therefore, is not attempted when there is reason to suspect extensive atheromatous changes in the coronary and cerebral vessels. In diabetic subjects and in patients over the age of 60 such anatomic changes are so universal that drastic blood pressure reduction is undesirable.

Methods

Surgical sympathectomy fails, so far as reduction of blood pressure is concerned, in 80 per cent of cases. Recovery of tone takes place in sympathectomized vessels,[14] and intermediate sympathetic ganglions[15] make complete sympathectomy impossible, even regionally. Selection of the small number of cases in which there is likelihood of response to sympathectomy would be desirable, but suitable tests have not yet been achieved. Salt depletion by a rice diet is seldom possible over a long period. Veratrum alkaloids frequently induce vomiting, and if they do not, there is often no effect on blood pressure. Alkaloids of ergot

only give small pressure reductions. I have had no success with 1-hydrazinophthalazine.[16]

Hexamethonium and related compounds, autonomic ganglion blocking agents introduced by Paton and Zaimis,[17] are at present the most successful. Unfortunately, their early oral use led to conflicting reports of either inefficacy or dangerous reactions. Irregularity of absorption from the alimentary tract was responsible for these doubts.

Given by subcutaneous injection,[18] this drug reduces blood pressure, particularly in the upright position for periods of five to seven hours after the injection. It prevents compensatory vasoconstriction in the upright position. Tolerance develops at first, and doses have to be built up over about three weeks, after which sensitivity remains practically unchanged. Doses may have to be unusually large, up to 750 mg. given as 2.5 ml. of 30 per cent solution deeply under the skin with a little procaine to avoid the pain which would otherwise result from such a hypertonic solution. Advantage should be taken of the postural reduction of pressure, and patients should be ambulant while taking the drug. Untoward side effects like meteorism, sickness and diarrhea subside in a matter of hours on omission of a dose. Injections are given at intervals of eight hours. Patients are seen in an outpatient clinic, and the degree of reduction of blood pressure within an hour of a subcutaneous injection is measured. Urethane of beta methyl choline, 25 mg. tablets orally, Urecholine or Mecothane helps to get rid of the dry mouth. Special glasses should be prescribed to assist reading while accommodation is paralyzed, and dark glasses are worn to avoid glare in sunshine.

With these measures improvement will be obtained in practically all cases of severe hypertension. In the best cases retinitis will regress, the size of the heart will diminish, and working capacity will be restored. Liability to thrombosis, however, may still remain, and when hypertensive heart disease has been present, a curious condition of organizing fibrinous edema may develop in the lungs. For this reason digitalization should be continued as well as hexamethonium in all patients with cardiac complications. Nephritic hypertension, provided uremia is not too severe, responds well to hexamethonium.

Other vasodilator influences such as meals, intercurrent fever, hot weather and salt depletion all increase sensitivity and prolong the action of hexamethonium. It is likely that some other vasodilator drug may be found which, in combination with hexamethonium, will prolong its action and improve still further blood pressure control.

The best proof of the efficacy of hexamethonium is found in cases of malignant and premalignant hypertension in which patients have been restored to active life and remain reasonably fit after periods of one to two years. The anatomic consequences of the vascular disorder, however, cannot be by-passed, and patients under treatment may still have thrombosis and dissecting aneurysms.

Years will elapse before the results from survival rates in complicated benign hypertension can be judged, but in the meantime one can say that parenteral hexamethonium therapy changes the course of severe hypertension in a manner favorable to the patient. It has given hope in malignant hypertension when previously there was none.

Since this paper was presented, details of results achieved in clinical trials have been published by Morrison[19] in the British Medical Journal.

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Ducane Road.

Role of Health Officer and Physician in Civil Defense Program

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For the first time in 138 years an enemy has the power to attack our cities in strong force, and for the first time that attack may come suddenly, with little or no warning. Industrial production has won the last two great wars for this country. Certainly an enemy knows this fact as well as we, and would be expected to strike at our home front first. Civil defense must take its place in our national security alongside military defense. No state or area can assume it is immune from attack.

Since the object of civil defense is the survival of the nation as a whole, its success will depend on the two principles of self help and mutual assistance. These two principles must be applied successively, from the home, the neighborhood, the community, on up through the state and nation. Everyone must be prepared to help the other one; each city must be in a position to help the other city, because we know that no city in this entire country is self sufficient; help must come in from the outside. But every city should be prepared to help itself until outside assistance can arrive. Plans must be made in peace time, since the opportunity is irrevocably lost during the confusion and urgency of war time.

A medical plan for civil defense should follow the same principles of program planning that one would use in any new public health activity. Every health officer should have a plan for disaster operations, whether enemy-caused or natural.

In June 1950 the National Security Resources Board recommended to the governors of the various states that they appoint their state health commissioners to be their state civil defense health services directors. At the same time it was recommended that local health officers be placed in charge of local civil defense health services. Generally speaking, these recommendations have been carried out. In every state the health officer has been given this responsibility; on the local level this pattern has also been followed, except in a few instances, mostly in some of the larger cities, where the responsibility has been divided between the health officer and a practicing physician, with the health officer's responsibility being limited to services commonly regarded as public health.

In my opinion this division is not sound, as experience has shown that the practicing physician does not have the time which the organization of health and medical services requires and deserves. All of the health and medical services are closely related and interlocked with each other and with the other civil defense services. The health officer has already been working with the various local groups which must be utilized in the over-all civil defense program — the welfare department, the police and fire services, the utilities, the city and county officials, the voluntary agencies, and of course, the local medical profession. He is accustomed to administrative and organizational work, and usually has some staff and clerical facilities that can be utilized.

Further, the practicing physicians constitute the group who will have to have the responsibility for the medical care of the injured. It is hardly fair to expect any of them to go beyond their own area of responsibility, in which they are not only especially fitted to serve, but actually in which no one else can serve in their place.

With this situation in mind, then, we can fairly well delineate the roles into which the health officer and the practicing physician will naturally fall.

The health officer must assume the leadership, assuming that he has been officially appointed local head of health and medical services. Certainly the first step would be establishing the top

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administrative structure, based on the official health agency.

The cooperation of all local professional groups is essential, and should be secured by the formation of an advisory committee. On this advisory committee should be the best representatives obtainable from the medical, dental, nursing, veterinary, hospital, pharmacy, and related professions. It might be well to have more than one advisory committee, because there are other groups, such as the Red Cross, the Parent-Teacher Association, the schools and the welfare department, with whom the health officer will be working closely. Many of these groups already have or will appoint civil defense committees; the top advisory committee could easily be composed of the chairmen of such committees.

The job to be done can be conveniently broken down into two main divisions; (1) Medical Services, and (2) Public Health Services.

Medical Services

The medical services branch should be headed by a physician as assistant health services director, preferably one with administrative experience, and if one who has had military combat experience is available, the community will indeed be fortunate. This branch is the area which must be serviced by the practicing physicians. The functions assigned to the medical services division include:

1. First aid and ambulance service
2. Hospital service
3. Casualty treatment and evacuation
4. Medical care of noncasualties
5. Pediatrics
6. Obstetrics
7. Dental care
8. Pharmacy service
9. Nursing care
10. Mental health

The local situation will determine how many of these sections may be combined; however, if practicable, each section should have a qualified person in charge.

Public Health Services

Functions in this branch are concerned only with civil defense and not with public health in the usual sense. Responsibilities of the branch, however, generally are those affecting the health of the entire public, as opposed to the responsibilities of the medical services branch which is concerned with casualties and special treatment needs of individuals. These functions will include:

1. Sanitation — general, water, food, milk, waste disposal, insect and rodent control.
2. Industrial health — with special reference to potential hazards that would develop as a result of disaster in plants.
3. Laboratory service — the public health laboratory could serve as the coordinating point for existing and improvised clinical laboratories in such matters as the procurement of personnel and equipment, and the organization of training programs.
4. Vital statistics — while this is a normal activity, it would need strengthening for a civil defense emergency.
5. Veterinary service — would include meat inspection, protection of food animals against biologic warfare, management of small animals and zoo animals.
6. Mortuary service — full advantage should be taken of the experience of private funeral directors.
7. Radiologic defense.
8. Biologic warfare defense.
9. Chemical warfare defense.

These last three in the larger cities or areas are often assigned to special divisions, when there are qualified personnel to handle them. Most health department staffs, however, can be taught radiologic monitoring and decontamination easily by qualified instructors who are usually made available from state sources. Biologic warfare defense can properly be handled by epidemiologists from the same source.

Chemical warfare is more likely to be used against military personnel rather than civilians.

While modern warfare carries with it the threat of the use of all of these weapons, we must remember that still 80 per cent of all the casualties are made up of traumatic wounds, burns, fractures and lacerations. The challenge of the atomic bomb to medical preparedness lies in the enormous number of deaths and injuries it can produce in the matter of a few seconds.

The health officer should also keep in mind that sanitation is a major problem in any emergency. Let us not lose track of it by the fear or glamour of radiation, or by new health department responsibilities for the care of the injured.

Radiation causes only a small proportion of

casualties. It has been used daily as a diagnostic and therapeutic aid for years.

The diagnosis and treatment of biologic warfare agents may be found in any good textbook of medicine.

Actions of and antidotes for chemical warfare are found in any good textbook of pharmacology.

So there is nothing new or mysterious in these weapons — that is, new or mysterious to the professional health or medical person. But we need to allay the anxiety of the public along this line, and place these hazards in their proper perspective. The health officer and the practicing physician can do this better than anyone else.

Detailed plans and guides for the organization of the health and special weapons defense are available. These have been developed with the advice and assistance of all professional groups, including the military. These Federal Civil Defense Administration publications may serve as guides that can be adapted easily to local situations.

Summary

Civil defense is essential to national security.

The basic principles of civil defense are self help and mutual aid.

Preparedness is the keynote of civil defense.

The health officer as a public official must assume responsibility and leadership.

We must look to the practicing physicians of the nation for the medical care of the injured and the noninjured.

While the hazards from radiologic, biologic, and chemical warfare must be considered, the majority of casualties will result from trauma and burns.

The protection of the community from an adverse environment, the assurance of a safe water and food supply, and the control of communicable diseases, will continue to be the major functions of the local health department in any emergency.

Detailed blueprints are available for the organization of the Health Services and Special Weapons Defense program.

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ABSTRACTS OF MEDICAL ARTICLES

Antibiotics in Acute Bacillary Dysentery, Observations in 1,408 Cases with Positive Cultures. By Lieut. Bernard T. Garfinkle (MC), U. S. Army Reserve, Lieut. Gerald M. Martin (MC), U. S. N., James Watt, M.D., Bethesda, Md., Capt. Fred J. Payne (MC), U. S. Army Reserve, Col. Richard P. Mason (MC), U. S. Army and Albert V. Hardy, M.D., Jacksonville, Fla. J. A. M. A. 151:1157-1159 (April 4) 1953.

A study of 1,408 bacteriologically positive cases of bacillary dysentery treated in a prisoner-of-war camp in Korea is presented. The disease in all cases of this series was severe, conforming to the classical description as found in the older medical literature. Bacillary dysentery of this degree of severity does not occur ordinarily in general population groups in the United States.

The organisms responsible for these severe illnesses were similar to those seen in other parts of the world. No unique types were isolated. The Flexner group predominated, and the more feared Shiga bacillus was found in fewer than 1 of every 200 cases. There is reason to believe that, to the extent cases seen elsewhere are due to the same types of Shigella, clinical response would be equally satisfactory.

Oxytetracycline ("Terramycin"), aureomycin, and chloramphenicol were effective in treating sulfonamide-resistant shigellosis in Korea. Four grams in three doses in 24 hours gave as satisfactory results as the larger doses ordinarily employed and better results than the same amount over a longer period or one-half as much in a single dose. Polymyxin B was a much less effective therapeutic agent.

Injury to the Genitourinary Tract During Surgery. By Curtis W. Bowman, M.D. Am. Surgeon 19:298-301 (March) 1953.

In pelvic surgery, this author states, injuries occurring during operation are more frequent than are late sequelae and may involve one ureter, both ureters, the bladder, and, especially in vaginal surgery, the base of the bladder. By far the greatest number of complications result from gynecologic operations, but these injuries also occur in other types of radical pelvic surgery and in urologic surgery.

The several types of injury to the ureters and the bladder are discussed. It is noted that many injuries occur in cases in which previous pelvic surgery or surgery of the lower portion of the abdomen has been performed. Preventive measures, including adequate survey of the genitourinary tract and, if at all indicated, cystoscopy, are outlined.

Repair of injury under various conditions is discussed. It is recognized that with the increasing importance of more radical surgery, and with the drugs, skill and equipment at hand to perform this surgery, the accidents discussed may be difficult to prevent. Nevertheless, it is concluded that adequate preoperative measures and careful preventive effort coupled with the principles common to all good surgery should facilitate avoidance, aid immediate recognition, and promote prompt repair of these injuries with less resultant total damage.

Stellate Ganglion Block, The Tissue Displacement Method. By Donald W. Smith, M.D. Am. J. Surg. 82:344-348 (Sept.) 1951.

Although stellate ganglion block is useful in numerous conditions which the author cites, it has not yet been adopted as universally as he thinks it should be. In his opinion the slow acceptance of this valuable diagnostic and therapeutic procedure, in the face of increasing indications for its use, appears to be due to the technical difficulties associated with the methods previously described.

He presents a method of stellate ganglion block which avoids the complications common to other methods in use. It is readily mastered by the least adept and is well tolerated by the patient. In his series of over 1,500 injections on 400 patients, there were 36 who had had as many as 30 stellate blocks. In use for six years without a single failure in interrupting the sympathetic innervation and without important vascular or visceral damage, the method has proved simple, safe and consistently effective.

The article has an extensive bibliography.

Modified Radical Mastoidectomy, Indications and Results. By Arthur L. Juers, M.D. A. M. A. Arch. Otolaryng. 57:245-256 (March) 1953.

The mode of genesis and the pathology of the various types of cholesteatoma are discussed as basic to a full understanding of the problems involved in selecting cases for and carrying out the technic of the modified radical mastoidectomy. Cholesteatoma formation secondary to an attic-retraction perforation is treated most satisfactorily by surgery in the author's experience, particularly if the size of the marginal perforation is such as to constitute a "bottleneck" to the egress of exfoliated epithelium. If, however, the disease process has virtually accomplished its own exteriorization of the attic-antral area, then conservative measures may suffice. The good preoperative hearing possessed by most patients with the attic-retraction type of cholesteatoma can be preserved by the modified radical (Bondy) mastoidectomy. If through neglect, however, the cholesteatoma is allowed to invade the middle ear, an irreversible conduction loss results and a complete radical mastoidectomy is usually necessary.

With interruption of the ossicular chain, a serviceable level of hearing may still be preserved if the stapes is not fixed and the tympanic cavity is intact. In the surgery of chronic suppurative otitis media, there is a possibility of conserving useful hearing, even though one of the ossicles is absent, if the diseased tissue can be removed and a tympanic cavity connected with the eustachian tube can be preserved. If, in a case selected for a modified radical mastoidectomy, the preoperative hearing tests indicate considerable conduction deafness, the ossicular chain should be inspected at surgery, and if mobility is impaired, the incus and head of the malleus should be removed. Improvement in hearing, however, can be anticipated only if the stapes is mobile and good cochlear function is present.

If the requirements of selection and the details of technic as discussed in this paper are met, the matrix in the medial attic-antral area may be preserved. Proper performance of this portion of the surgical technic requires magnification.

Seven illustrative cases are presented.

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From Our President

A Formula for Living

Many years ago I ran across the message which I am giving you for this month's Journal. I do not know the author, and wish that I could give him due credit for this inspiring series of thoughts. It was copied in the early thirties and has been periodically read by me, with increasing profit at each reading. Here it is, for your consideration:

"Go quietly amid the noise and haste and remember what peace there may be in silence. As far as possible, be on good terms with all persons. Speak your truth quietly and clearly and listen to others; they, too, have their story to tell. Avoid loud and aggressive persons; they are vexatious to the spirit. If you compare yourself with others, you may become vain or bitter, for there always will be greater and smaller persons than yourself. Enjoy your achievements as well as your plans. Keep interested in your own career, however humble; it is a real possession in the changing fortunes of time. Exercise caution in your business affairs, for there are many persons whose word is worthless. But let this not blind you to what virtue there is. Be yourself. Especially do not feign affection. Neither be cynical about love; for in the face of all aridity and disenchantment, it is as perennial as the grass. Take kindly the counsel of the years, gracefully surrendering the things of youth. Do not distress yourself with dark imaginings. Be gentle with yourself. You are a child of the universe no less than the trees and the stars; you have a right to be here. And whether or not it is clear to you, no doubt the universe is unfolding as it should.

"Therefore, be at peace with God, whatever you conceive Him to be. And whatever your labors and aspirations, in the noisy confusion of life, keep peace in your soul. With all its sham, drudgery and broken dreams, it is still a beautiful world. Be cheerful. Strive to be happy."

Frederick K. Herpel

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The Beloved Physician

The story of the Nativity of Jesus in the second chapter of the Gospel of St. Luke has been called the most beautiful piece of writing ever set down by the hand of man. We can be doubly proud that it, along with the stirring account of the early Church called the Acts of the Apostles, was also the work of a physician.

Paul refers to Luke in the Epistle to the Colossians as "the beloved physician." And if the reference in II Corinthians to "the brother whose praise is in the gospel throughout all the churches" really means Luke, as many scholars believe, he was also an active teacher. A close study of the writings of this first century Christian physician shows that he was a cultured and educated Greek with considerable literary talent.

The world of Luke's day was an amazingly cosmopolitan one. Why then would a cultured and educated Greek physician turn aside from it and give his life to spreading the teachings of what was then only a minor Jewish faith, although destined to turn the world upside down? The answer seems to lie in two sources: Luke's loyalty to Paul, and his firm conviction of the importance of the teachings of Jesus of Nazareth.

Luke must have lived in intimate contact with Paul throughout much of his life and work following his conversion on the road to Damascus. The accounts in the Acts are so vivid — many of them in the first person — that one can hardly doubt that Luke was actually on the scene. Paul, we know, was sickly, troubled with a recurrent eye inflammation and probably psychosomatic troubles as well, since one so dynamic must inevitably have suffered the effects of the tremendous emotional drive in his body organs. As both physician and biographer, Luke undoubtedly lived in close contact with Paul, probably giving up whatever professional life he might have had to follow this man of many controversies.

The most important factor in leading Luke to become a follower of the Way of Jesus, however, must have been the simplicity of the Master's teachings. The writings of many Greek philosophers contain ideas and ideals that are amazingly similar to the teachings of Jesus. So when Luke heard from Peter and the others who had listened to the Master how Jesus had said, "If any man will come after me, let him say 'No' to self," he easily understood the meaning. In becoming a physician, Luke had actually said "No" to self, for a doctor of medicine serves others. And Luke said "No" again when he gave up his own career to accompany his most famous patient and to become the biographer of the early Church. Undoubtedly, too, he learned the tremendous spirit-

ual satisfaction, the rewards of peace and security of soul that come only from setting the welfare of others above any selfish desire, the greatest reward in fact that comes to the physician.

Still another teaching of Jesus must have appealed greatly to Luke, the simple assurance that, "Are not five sparrows sold for two farthings, and not one of them is forgotten before God." Everywhere in Luke's writings we find emphasized this simple concept of individual dignity and importance in the eyes of God, as if it were a torch he was holding high for all to see.

As to Luke's later life, many authorities believe he wrote his Gospel during the two years that Paul was imprisoned in Caesarea. He journeyed to Rome with Paul and there wrote the Acts of the Apostles. And it seems likely that Luke was present during those terrible days when the Christians were massacred by thousands at the order of the depraved Emperor Nero, and when Paul and Peter reputedly met their deaths.

Of Luke himself we read in the Monarchian Prologue to his Gospel dating from about 200 A.D.: "Luke, by nation a Syrian of Antioch, a disciple of the Apostles, was afterward a follower of Paul until his martyrdom, serving the Lord blamelessly. For having neither wife nor children, he died in Bithynia at the age of seventy-four, filled with the Holy Spirit."

At Christmastime, every one of us should read again the beautiful accounts of the Nativity and the life of Jesus of Nazareth as set down by "the beloved physician," who might well be called the "ideal physician" as well, the man called Luke.

Frank G. Slaughter

Editor's Note: Dr. Frank G. Slaughter, distinguished physician-author of Jacksonville, is an eminent authority on Biblical history. In his historical novel, *The Road to Bithynia,* Dr. Slaughter vividly portrays the practice of medicine in Biblical times by capturing the personality of Luke the physician.

Wanted — Men of Good Will

Traditionally, the holiday season now at hand is a time of rejoicing. Its observance through the centuries has afforded opportunity for the expression of the kindliness of men of good will toward others. This spirit abroad in the land at this time is one of hope and good cheer, a fitting climax to the year that is spent and a wholesome approach to the year ahead.

But why should this spirit be seasonal? Was there ever a time when good will among men was needed more than in this time of world confusion and perplexity when wars blow hot and blow cold, when peace so earnestly desired in most quarters remains ever elusive?

In the global age now upon us dark are the splotches on the horizon. Atomic weapons, hydrogen bombs, enslavement of human beings mar the pattern of good will as do many corroding factors. Nevertheless, there is a pattern firmly woven in the hearts of good men everywhere; it is the leaven which will yet lift this sorry world above its mundane concepts. Even now we begin to hear much of the urgency of channeling nuclear energy into peacetime pursuits. Certainly the world has witnessed a spectacular and sincere outpouring of help on a scale such as has not been dreamed of heretofore.

In October, at the cornerstone laying of the massive new structure which will house the Armed Forces Institute of Pathology, Dr. Casberg made this fitting remark, "It is significant that the first structure erected by the joint Armed Forces is not an arsenal or a battleship but a building dedicated to the service of humanity." True, its outside structure is one of the few buildings in this country designed to resist atomic bombs. But inside, pathologists of the three services, members of a vital branch of the medical profession, will labor to benefit their fellowmen.

In times like these, have we the courage and the faith to look forward to a better world wherein greater human understanding of humanity itself shall rule? Men of medicine are assuredly making an effort to exercise leadership toward those ideals which promote good will among men. Through the American Medical Association, the World Medical Association, and the World Health Organization of the United Nations they are working effectively with many groups, medical and nonmedical, throughout the world to translate ideal concepts into practical concepts.

Wisely, they do not anticipate spectacular results in such a venture. As the spirit of peace on earth and good will among men gradually pervades this old world, physicians will be in the vanguard of those who are instrumental in the achievement of this goal.

The Editor Invites Your Contributions on

Data of Notable Interest

Warning Against 'Delusion' in Doctor Shortage

The Secretary of Health, Education, and Welfare had a word of warning to offer in her address at the annual meeting of the American Hospital Association recently. "Our doctor shortage looks non-existent at first glance, but we should not delude ourselves," commented Mrs. Hobby. Then she made these comparisons: "Before World War I we were graduating roughly 6,000 doctors a year. And now we are graduating only about 7,000 a year. In the U. S., while the population has jumped from 105 million to 160 million, the number of doctors graduating each year has climbed only 1,000."

To save the average American family "from destruction by catastrophic illnesses" no way has yet been found, the Secretary remarked and added that the answer lies within the private enterprise system. To this end, she would have all organizations in the field of medicine apply "their brains, their experience, and their funds to the solving of this problem."

Among other comments made by the Secretary was the statement that the overwhelming majority of the American people have no desire whatsoever for socialized medicine in any form. How right she is, and how refreshing to have that viewpoint appreciated and aired from Washington. She observed also that the uneven distribution of doctors finds a patient in a major city with recourse to six or eight specialists while a person in a small town may have no doctor within 50 or more miles. She is of course doubtless aware that efforts are being made to handle the problem of uneven distribution constructively.

Another British Straw in the Wind

What next? Is there no end? Not to socialized medicine propaganda, it seems. Miss Patricia Hornsby-Smith, a member of the British Parliament and presently serving as Parliamentary Secretary to the Ministry of Health is coming to this country on a Smith-Mundt grant. The British Information Services through its Chicago office has informed the American Medical Association that Miss Hornsby-Smith, a gifted speaker, "is most anxious to have a chance to talk to any kind of group — the bigger and rougher the better — on the National Health Service." The desire is quite in character for a propagandist, and it would appear that the lady puts herself and her cause on the defensive even before she arrives, as well she may.

But how come the Smith-Mundt grant for such a purpose? It was in 1948 during the 80th Congress that the Smith-Mundt bill became Public Law 402. The Congress passed it "to promote the better understanding of the U. S. among the peoples of the world and to strengthen international relations." It would seem that the law is, to say the least, being broadly interpreted in this instance, if not interpreted in reverse. Just how her proposed talks on behalf of the British socialized medical care plan can "promote the better understanding of the U. S." is somewhat obscure. Doubtless, though, the visitor will wish to see Florida while she is on tour in this country on the taxpayers' money, even though she may find her audiences, if any, not "bigger and rougher" but smaller and smaller, diminishing to the vanishing point.

Teen Age Hazards

December with its holiday cheer and customary conviviality is also, because of its festive air, a month of extra hazards, especially to the youth of the land. It is an appropriate time to dwell again in these columns, as frequently in the past, on hazards and especially the major role of accidents as a cause of mortality in children. Physicians, public health officials and educators attending the fourth National Conference on Physicians and Schools recently were reminded by President McCormick of the American Medical Association that health educators should put stress here, for the accident figure represents more than the next six causes of death combined.

It is particularly noteworthy that teen age children in the 15 to 19 year group die chiefly from accidents while driving cars. A new study by insurance statisticians indicates that in the 18 to 19 year group, motor fatalities are responsible for almost two thirds of accidental deaths among boys and about four fifths among girls.

Some 18,000 children lose their lives each year from accidents. A hundred times that many doubtless are injured at school, en route to and from school, or at home. "Accidents kill and cripple more of our children than all the infectious diseases of childhood put together," warns Dr. Martha M. Eliot, chief of the Children's Bureau of the Department of Health, Education, and Welfare. "If parents understood the accident

problem and were as concerned about it as they are about polio and other contagious diseases, the toll of childhood deaths . . . could be cut sharply." She recently released a new report, "Childhood Mortality From Accidents," which shows that the groups most prone to accidents are babies under 1 year of age and children between 15 and 19 years of age. Choking from inhaling or eating foods or other objects causes more than one third of the accidental deaths among infants. Being run into or backed over by automobiles is the great danger for the 1 to 4 and 5 to 9 age groups. While the automobile mishaps decrease in the 10 to 14 age bracket, drowning fatalities increase, but in the later teens driving an automobile is the major threat to life.

As for other hazards, cancer, mainly leukemia, ranks first among disease killers of teen age boys and girls, accounting for approximately one fifth of the deaths among them. Diseases of the heart, including rheumatic fever, rank second. Acute poliomyelitis outranks tuberculosis except for girls of 18 and 19, among whom tuberculosis causes about one ninth of all deaths from disease.

Defective vision and poor teeth are present in a high proportion of children in their teens. Too, the effects of poor eating habits are evident, especially among girls. Mental and emotional problems loom large also. Today's tendency to early marriage and parenthood is reflected in a death rate approaching 6 per cent among girls in the 18 to 19 age group due to pregnancy and childbirth.

In the prevention of teen age hazards, parents and physicians alike have a vital role that is not to be neglected.

Expanding Concept of Legal Medicine

The introduction of legal medicine into the professional training of physicians is a relatively recent development in this country. The pioneer in this respect was the Harvard Medical School, which first took steps toward the establishment of a full university department of legal medicine by establishing in 1937 a full time chair of legal medicine. Within three years a Department of Legal Medicine was in operation.

During the past 15 years, this department has devoted its principal efforts to refining methods of obtaining postmortem evidence and to the training of medical examiners. Over this period appropriations of $107,000 from the Rockefeller Foundation have aided in the promotion of this objective. The 1952 report of the Foundation, recently released, brings word of a further grant of $100,000 to enable the department to carry out a four year experimental program.

The plan now is to expand the concept of legal medicine beyond the present emphasis on forensic pathology. It has become increasingly clear that medicine and the law are intimately involved in many other matters besides providing accurate and impartial evidence by careful postmortem examination in crimes of violence, as important as that is. Many persons, for example, who commit crimes or become involved in civil suits do so because they experience personal difficulties which physicians regard as illnesses. Although this fact has long been recognized, today's procedures for introducing and evaluating evidence bearing on this question are admittedly inadequate. The inaccuracy of present knowledge about mental illness of course is one source of the trouble. Doubtless, however, the lack of understanding between the law and medicine as to what constitutes evidence and the ways in which it should be handled in reaching a judgment constitutes a major factor. In trials involving compensation for physical injury a similar problem is encountered. These difficulties become an increasingly important problem in these days of almost universal insurance.

With the Harvard Law School eager to cooperate, this project looking toward the solution of such problems is constructive and should be rewarding. It is a step forward in medical education, which long has neglected medicolegal training, and benefits should accrue both to the medical and legal professions and to the public.

Intergovernmental Relations Commission Completed

In September, 14 appointments by President Eisenhower completed the 25 member Commission on Intergovernmental Relations. Authorized in July, the commission is under instructions from the Congress to report by next March 1 on problems in the interrelationships of federal, state, and local governments. Because of delay in filling out the membership, only five months remained in which to complete a comprehensive survey and draft recommendations to the Congress, but under the leadership of the chairman, Clarence E. Manion, former dean of the Notre Dame Law School, rapid fire operations were expected. His

appointment was announced some weeks previously, and he began at once to prepare for the survey.

The Manion Commission's objective is to determine what functions, including those in health and social fields, could be returned to the states, counties, and municipalities. At the same time the federal government would withdraw from certain taxation areas in favor of the states so that the latter could afford to assume the shifted responsibilities.

The latest presidential appointments include seven representatives of the general public, among them Samuel H. Jones, former governor of Louisiana; four governors, two of whom are John S. Battle of Virginia and Allan Shivers of Texas; and three federal executives, namely, Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare, Marion B. Folsom, Undersecretary of the Treasury, and Val Peterson, Administrator of the Federal Civil Defense Administration. Earlier, five Senators were appointed to the commission by Vice President Nixon and five Representatives by House Speaker Joseph Martin.

The recommendations of this commission to the Congress will be awaited with particular interest, as will their ultimate disposition by the Congress. Certainly any activities to promote a trend toward decentralization of power in Washington and restoration or allocation of certain appropriate functions to the states would be welcomed as another roadblock on the highway to socialism, down which this country in recer t years has been coasting.

Southern Medical Association Forty-Seventh Annual Meeting Atlanta, October 26-29

Dr. Walter C. Jones of Miami, president of the Southern Medical Association, presided over the Forty-Seventh Annual Meeting in Atlanta, October 26-29. Dr. Jones delivered his presidential address, "Forgive Us Our Debts" at the opening assembly, which was a public session. During this same assembly, Dr. Frank G. Slaughter of Jacksonville spoke on "The Beloved Physician," St. Luke.

During the first general session, Dr. Jones was presented with the past president's medal. This followed the installation as president of Dr. Alphonse McMahon of St. Louis, Mo.

Members of the Florida Medical Association presenting scientific exhibits during the meeting included: Drs. George F. Schmitt Jr. and James J. Griffitts of Miami, and J. Brown Farrior of Tampa.

Dr. William L. Musser of Winter Park presented a paper at a meeting of the Section on General Practice of which Dr. Walter W. Sackett Jr. of Miami is secretary. At a meeting of the Section on Medicine, Drs. Martin S. Belle, Morton M. Halpern and Louis Lemberg of Miami presented a paper.

Dr. Donald F. Marion of Miami was moderator of a panel on "Amebiasis" at a meeting of the Section on Gastroenterology. At a meeting of the Section on Surgery, Drs. Donald W. Smith, secretary of the Section, Richard M. Fleming and Rudolph E. Drosd, all of Miami, and Hawley H. Seiler of Tampa read papers. Dr. Milton M. Coplan of Miami, vice chairman of the Section on Urology, took part in the meetings of that Section.

Dr. George F. Schmitt Jr. spoke at a meeting of the Section on Obstetrics. Dr. Claude G. Mentzer of Miami, chairman of the Section on Proctology, gave his chairman's address at a meeting of this Section. Dr. George Williams Jr. of Miami also spoke at a meeting of the Section on Proctology.

Dr. G. Dekle Taylor of Jacksonville spoke at a meeting of the Section on Ophthalmology and Otolaryngology. A paper was presented by Dr. Benjamin G. Oren of Miami at a meeting of the Southern Society of Cancer Cytology.

Registration

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Medical District Meetings, 1953

Meetings were held this year in Tallahassee, October 19, St. Augustine, October 20, Tampa, October 21, and West Palm Beach, October 22. Association members had an opportunity at these four meetings to know better their state officers and learn from them about important state level activities. Two scientific papers were also presented at each meeting.

Dr. John D. Milton, chairman of Council, presided at both the scientific assembly and the general sesson of each of the four meetings.

Drs. Frederick K. Herpel, president, Duncan T. McEwan, president-elect, and Samuel M. Day, secretary-treasurer, were present at all of the meetings and gave short talks. Dr. Shaler Richardson, editor of The Journal, was also present at the Tallahassee meeting and spoke on the progress of The Journal this year.

Dr. Richard C. Cumming, representing the Marion County Medical Society, attended all the meetings and discussed a proposal to establish a memorial to the late Dr. Stewart Thompson.

Large registration is not expected at every medical district meeting, since there is only one-half day and evening in the schedule. Those attending, however, were enthusiastic in their favorable comments, and Association officers were rewarded with an opportunity to meet new colleagues and renew old acquaintances.

The Woman's Auxiliary to the Florida Medical Association, under the leadership of Mrs. Thomas C. Kenaston, president, arranged workshop meetings for the ladies during the afternoon and joined the doctors for the dinner in the evening.

Northwest Medical District

October 19 — Tallahassee

Dr. John D. Milton, chairman of Council, presided at the meeting and was assisted at the scientific session by Dr. William C. Roberts for Dr. Francis M. Watson, councilor of District 1, and at the general session by Dr. George S. Palmer, councilor of District 2.

Dr. Charles F. James Jr., president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, gave the address of welcome as the meeting was called to order at 2:30 p.m.

Following the address of welcome, scientific papers were presented by Dr. Francisco A. Hernandez (by invitation) of Miami on "The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery," and Dr. Milton S. Saslaw (by invitation) of Miami on "Paradoxical Skin Response in Rheumatic Activity: A Possible Test."

State officers gave short talks during the general session.

Refreshments and dinner were served by the host society.

The 1954 meeting will be in Marianna. Total registration was 72, of which 56 were Association members (A District 45) and 16 visitors. Among those registered were past presidents Julius C. Davis, Robert B. McIver, Shaler Richardson, Herbert L. Bryans and Edward Jelks.

Registration

APALACHICOLA: Photis J. Nichols. BLOUNTSTOWN: Grayson C. Snyder. CHATTAHOOCHEE: William W. Rogers. CHIPLEY: Bayllye W. Dalton. JACKSONVILLE: Samuel M. Day, Edward Jelks, Robert B. McIver, Nelson A. Murray, Shaler Richardson, Wilson T. Sowder. LAKE CITY: Laurie J. Arnold Jr., Robert B. Harkness. MADISON: Harry A. Nevel. MARIANNA:

Jabe A. Breland, James T. Cook Jr. MIAMI: Francisco A. Hernandez, John D. Milton, Milton S. Saslaw. OCALA: Richard C. Cumming. ORLANDO: Duncan T. McEwan. PANAMA CITY: William C. Roberts. PENSACOLA: Herbert L. Bryans. PORT ST. JOE: Albert L. Ward. QUINCY: Julius C. Davis, Taylor W. Griffin, George H. Massey, J. Lloyd Massey. TALLAHASSEE: Frank E. All, Edson J. Andrews, Joseph M. Bistowish Jr., G. Wilmot Brown Jr., Merritt R. Clements, Paul J. Coughlin, Laurie L. Dozier, Ernest W. Ekermeyer, T. Bert Fletcher Jr., George H. Garmany, Arthur J. Henry Jr., Francis T. Holland, Charles F. James Jr., Clarence W. Ketchum, Odis G. Kendrick Sr., Odis G. Kendrick Jr., David J. McCulloch, Lawrence C. Manni, Robert H. Mickler, Raney A. Oven, George S. Palmer, James H. Pound, Bricey M. Rhodes, Henry L. Smith Jr., Wm. E. Westcott, Benjamin A. Wilkinson, John L. Williams. WEST PALM BEACH: Frederick K. Herpel. WEWAHITCHKA: Harold B. Canning.

VISITING DOCTORS—CHATTAHOOCHEE: James E. Thompson. GRACEVILLE: William W. Richardson. TALLAHASSEE: Thomas J. Bixler, J. Paul Chapin, William J. Hutchison, J. Elizabeth Jeffress, Nelson H. Kraeft, DeHart Krans, George I. Lebess, George H. McCain, Philip B. Smith, Earl E. Wilkison. ECUADOR - GUAYAQUIL: Emilio Jaramillo.

OTHER GUESTS—JACKSONVILLE: Ernest Gibson, W. Harold Parham, H. A. Schroder.

Northeast Medical District

St. Augustine — October 20

The meeting was held at the Ponce de Leon Golf Club with Dr. William C. Thomas Jr., councilor of District 3, presiding with Dr. Milton at the scientific assembly, and Dr. Thomas C. Kenaston, councilor of District 4, assisting at the general session.

At 2:30 p.m., members and guests were welcomed by Dr. John M. Canakaris, president of the St. Johns County Medical Society.

The scientific program was opened by Dr. C. Ashley Bird of Jacksonville who spoke on "Diagnosis and Treatment of Intracranial Aneurysms." Dr. Francisco A. Hernandez (by invitation) of Miami spoke on "The Clinical Differentiation of Congenital Heart Lesions Amenable to Surgery."

Short talks of statewide interest were presented by the state officers present. Refreshments and a barbecue were served by the host society.

At the general session, Sanford was selected as the meeting place for 1954. Total registration was 93, of which 83 were Association members (B District 80) and 10 visitors. Among those registered were past presidents John S. McEwan, Frederick J. Waas, Edward Jelks, Eugene G. Peek Sr., Herbert E. White, and Robert B. McIver.

Registration

BUNNELL: John M. Canakaris. COCOA: Thomas C. Kenaston. DAYTONA BEACH: John J. Cheleden, David W. Goddard, Achille A. Monaco, Ludo von Meysenbug, Norman E. Williams. GAINESVILLE: F. Emory Bell, John E. Maines Jr., Walter E. Murphree, Stuart D. Scott, William C. Thomas Jr. HASTINGS: Alfred W. Norris. HOLLY HILL: Frank A. Sica. JACKSONVILLE: S. James Beale, C. Ashley Bird, John B. Black, James L. Borland, Frederick H. Bowen, Turner Z. Cason, Robert H. Cleveland, William C. Croom Jr., Samuel M. Day, Simon D. Doff, Lucien Y. Dyrenforth, Leonard Garten, A. Judson Graves, Ivan Isaacs, Edward Jelks, A. Denton Jones, F. Gordon King, Raymond H. King, James G. Lyerly, Charles F. McCrory, Robert B. McIver, Bernard L. N. Morgan, Nelson A. Murray, Morris A. Price, Ferdinand Richards, Clarence D. Rollins, Robert G. Rosser Jr., E. Thomas Sellers, Clarence M. Sharp, Richard G. Skinner Jr., Wilson T. Sowder, George M. Stubbs, Wilbur C. Sumner, Max Suter, William A. Van Nortwick, Frederick J. Waas, Donald T. White Jr., Albert H. Wilkinson, Ashbel C. Williams, Jonathan H. Wood. MELBOURNE: Oswald A. Holzer. MIAMI: Francisco A Hernandez, John D. Milton. OCALA: William H. Anderson Jr., Richard C. Cumming, Carl S. Lytle, Eugene G. Peek Sr. ORLANDO: Thomas R. Collins, Horace A. Day, Duncan T. McEwan, John S. McEwan, Meredith Mallory, Robert E. Zellner. PALATKA: Lawrence G Hebel, James A. Long Jr. (Col.) ST. AUGUSTINE: Reddin Britt, S. Raymond Cafaro, James J. DeVito, Charles C. Grace, George C. Hopkins, Vernon A. Lockwood, Hardgrove S. Norris, Donald T. Rankin, Joseph A Shelley, Herbert E. White. SANFORD: J. Clifford Boyce, Thomas F. McDaniel, John M. Morgan. WEST PALM BEACH: Frederick K. Herpel.

VISITING DOCTORS — DAYTONA BEACH: Gerald S. Williams. GAINESVILLE: Carl M. Herbert Jr. JACKSONVILLE: Roy M. Baker. OCALA: E. Laurence Scott. PENNEY FARMS: Otis Marshall. ST. AUGUSTINE: Reuben J. Plant Jr.

OTHER GUESTS — DAYTONA BEACH: Wm. G. Truesdell. JACKSONVILLE: Ernest Gibson, W. Harold Parham, H. A. Schroder.

Southwest Medical District

October 21 — Tampa

Dr. Clyde O. Anderson, councilor of District 5, assisted Dr. Milton in presiding at the scientific assembly, and Dr. Emmett E. Martin, councilor of District 6, presided with Dr. Milton at the general session.

Dr. Arthur R. Knauf, president of the Hillsborough County Medical Association, welcomed the members and guests.

Dr. Edward I. Melich of Bay Pines spoke on "Digitalis Brought Up To Date," and Dr. Milton S. Saslaw (by invitation) of Miami spoke on "Paradoxical Skin Response in Rheumatic Activity," at the scientific session.

Association officers present gave short talks of statewide interest at the afternoon general session.

Refreshments and dinner were served by the host society.

The 1954 meeting place chosen at the general session is Sarasota. Total registration was 103, of which 94 were Association members (C District 84) and 9 visitors. Past presidents in attendance were William M. Rowlett, David R. Murphey Jr., and Robert B. McIver.

Registration

ARCADIA: Henry P. Bevis, Gordon H. McSwain. BARTOW: Milo H. Holden. BAY PINES: Edward I. Melich. BRADENTON: Roderic O. Jones, John S. Neill. BROOKSVILLE: Warren T. Loftis Jr. DADE CITY: W. Wardlaw Jones. FORT MYERS: Ernest Bostelman, William H. Grace, H. Quillian Jones. HAINES CITY: Emmett E. Martin. JACKSONVILLE: Samuel M. Day, Albert V. Hardy, Robert B. McIver, Lorenzo L. Parks, Wilson T. Sowder. LAKELAND: Jere W. Annis. MIAMI: John D. Milton, Milton S. Saslaw. OCALA: Richard C. Cumming. ORLANDO: Duncan T. McEwan. PLANT CITY: Frank Chambers Jr. PUNTA GORDA: Walter B. Clement, Roscoe S. Maxwell. ST. PETERSBURG: Clyde O. Anderson, Curtis W. Bowman, John P. Ferrell, N. Worth Gable, Abraham J. Gorday, E. Ransom Koontz, Francis H. Langley, Norval M. Marr, Alvin L. Mills, Benjamin H. Sullivan, Roderick C. Webb. SARASOTA: Henry G. Morton, William A. Shannon, Melvin M. Simmons, Henry J. Vomacka, Millard B. White. TAMPA: Samuel H. Adams, Efrain C. Azmitia, Richard A. Bagby, Collin F. Baker Jr., Ernest R. Bourkard, C. MacKenzie Brown, Harold O. Brown, J. Robert Campbell, Harold Carron, Frank V. Chappell, C. Frank Chunn, Herschel G. Cole, Rosalind E. Cummings, Wm. P. Duncan, Joshua C. Dickinson, J. Brown Farrior, John D. Flynn, Elsie M. Gilbert, Kenneth G. Gould, Chas. McC. Gray, H. Phillip Hampton, Linus W. Hewit, Richard S. Hodes, J. M. Ingram Jr., Oscar A. Juarez, Arthur R. Knauf, Frank T. Linz, Paul J. McCloskey, Thomas E. McKell, Alfonso F. Massaro, Eugene B. Maxwell, Frank C. Metzger, Joseph A. Minardi, David R. Murphey Jr., Hugh E. Parsons, Julien C. Pate Sr., Julien C. Pate Jr., James N. Patterson, Joseph A. Pendino, Lee T. Rector, Curtis G. Rorebeck, William M. Rowlett, Edward F. Shaver, Vergil G. Stead, Alvord L. Stone, Joseph W. Taylor Sr., William W. Trice Jr., Mason Trupp, Morris Waisman, Augustine S. Weekley, Wesley W. Wilson. VENICE: Samuel E. Kaplan. WEST PALM BEACH: Frederick K. Herpel.

VISITING DOCTORS — JACKSONVILLE: G. D. Barton. ST. PETERSBURG: Conrad F. Ernst. SARASOTA: John S. Bracken. TAMPA: Marvin L. Cullen, James B. Hodge Jr. CANADA — KINGSVILLE, ONTARIO: Eoin A. Currie.

OTHER GUESTS — JACKSONVILLE: Ernest Gibson, W. Harold Parham, H. A. Schroder.

Southeast Medical District

October 22 — West Palm Beach

Presiding with Dr. Milton at the scientific assembly was Dr. Erasmus B. Hardee, councilor of District 7. Dr. Russell B. Carson, councilor of District 8, assisted Dr. Milton in presiding at the general session.

Dr. Graham W. King Jr., president of the Palm Beach County Medical Society, gave the address of welcome.

Dr. George F. Schmitt Jr. of Miami presented a scientific paper on "The Fundamentals of Fluid and Electrolyte Balance (Explanation of Milliequivalents)." Dr. George W. Robertson III of Miami then spoke on "The Treatment of Injuries of the Face and Head."

Officers of the state association presented talks of interest to all members during the general session. Refreshments and dinner were then served by the host society.

The 1954 meeting will be held in Vero Beach. Total registration was 72, of which 63 were Association members (D District 59) and 9 visitors. Among visitors attending the meeting was Sen. Russell O. Morrow of Lake Worth. A past president in attendance was Robert B. McIver.

Registration

DANIA: Fred E. Brammer. DELRAY BEACH: Graham W. King Jr., James R. Nieder. FORT LAUDERDALE: Curtis D. Benton Jr., Russell B. Carson, Scottie J. Wilson. FORT PIERCE: John T. McDermid, Adrian M. Sample, Richard F. Sinnott. HIALEAH: Albert W. McCorkle. JACKSONVILE: Samuel M. Day, Robert B. McIver. LAKE WORTH: A. Scott Turk, Edward W. Wood. MIAMI: Reuben B. Chrisman Jr., Joseph H. Crawley, Edward W. Cullipher, Francis W. Glenn, John D. Milton, Maxine R. Perdue, George W. Robertson III, George F. Schmitt Jr., Franz H. Stewart. MIAMI SHORES: Robert A. Mayer. MIAMI SPRINGS: Clyde T. Thompson. OCALA: Richard C. Cumming. ORLANDO: Duncan T. McEwan. PALM BEACH: David A. Newman, Bailey B. Sory Jr. RIVIERA BEACH: Robert Y. Wheelihan. VERO BEACH: Erasmus B. Hardee. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, Horace D. Atkinson, John M. Baber, Harry E. Bierley, Edwin W. Brown, James L. Carlisle, Victor Clarholm, Thomas E. Daly, George M. Dawson, Hugh Dortch Jr., William H. Gardner, Frederick K. Herpel, Russell D. D. Hoover, Oliver L. Jones, W. Ambrose McGee, Lloyd J. Netto, Walter R. Newbern, Theodore Norley, James C. Nowling, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond R. Preefer, Atwell B. Pride (Col.), William H. Proctor, Murray D. Sigman, Joseph R. Skyer, James R. Sory, Vale D. Stone, Laurie R. Teasdale, Wm. E. Van Landingham.

VISITING DOCTORS — LAKE WORTH: Robert O. Brockway, Arthur T. Rask. VERO BEACH: B. Bowman Guerin. WEST PALM BEACH: Philip O. Lichtblau. WISCONSIN — MADISON: Mabel G. Masten.

OTHER GUESTS — JACKSONVILLE: Ernest Gibson, W. Harold Parham, H. A. Schroder. LAKE WORTH: Sen. Russell O. Morrow.

THE EIGHTIETH ANNUAL CONVENTION

of the

FLORIDA MEDICAL ASSOCIATION

HOLLYWOOD BEACH HOTEL APRIL 25-28, 1954

They Will Look Here

The past pages of The Journal recall for us the events of yesterday which marked the progress of medicine in Florida. Great men whose names are no longer heard live again in the pages of The Journal of their time.

Recently, a group of young men and women from all sections of Florida started another routine day of classwork. This was not remarkable because it was September 1953 and thousands were returning to schools over the state.

For the Florida Medical Association this opening classroom scene marked an event of some importance. Twenty-six well grounded, ambitious students from Florida were meeting their first day of clinical work. Seven physicians of the Association were starting the first teaching in Physical Diagnosis at the University of Miami School of Medicine.

In years to come, as the pages of The Journal are turned back, this record will be found. The pages will show that all sections and all interests within the Association noted with pleasure this milestone in the development of medicine. Here will be recorded a note of congratulations and good wishes to this first group of medical students in the state.

When the story of early undergraduate medical teaching in Florida is sought, it will be found here.

Franz H. Stewart



Physical Diagnosis Class

The Sophomore Class of the University of Miami School of Medicine meets at Jackson Memorial Hospital for the first clinical teaching. First row, left to right: John Joseph Favata, Tampa; Sidney Adler, Quincy; Norman Maurice Kenyon, Clearwater; Harold Eugene Register, Orlando; Sheldon E. Kalmutz, West Palm Beach; Richard G. Alper, Miami Beach; Emilio D. Echevarria, Tampa. Second row: Frank G. Wilson, Miami; Richard Vernon Surgnier, Gibsonton; James Omar Dailey, Micanopy; James Russell Forlaw, Jacksonville; Milton H. Hillman, Miami Beach; John Clayton Purger, St. Petersburg; Ernest Randolph Whitcomb, Jacksonville. Third row: Curtis Wilford Cannon, St. Augustine; Margaret E. Winn, Lake Butler; Nathaniel M. Weems Jr., Boynton Beach; Elaine Ross, Coral Gables; Kathleen Everitt, Panama City; Everett Nelson Bowser, Orlando; Willis Alston Brown III, Tampa. Fourth row: Kenneth Calvert Kiehl, Orlando; Rodney Lynn Belcher, Ford Lauderdale; Arvid John Peterson, Pierson; Louis John Tsavaris, Tarpon Springs. Not pictured is James A. Gervers, Port Tampa City.

Standing: Instructiors for this course, left to right, are: Dr. Louis Lemberg, Dr. William M. Straight, Dr. Archie McCallister Jr., Dr. Jack L. Wright, Dr. Seymour B. London, Dr. Martin S. Belle and Dr. Francisco A. Hernandez.

Midwinter Seminar in Ophthalmology and Otolaryngology Miami Beach, Jan. 18-23, 1954

During the week of January 18, the annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will be held at Miami Beach. This will be the eighth year the meeting has been held, always in Miami Beach, and as in recent years the headquarters will be the Sans Souci Hotel. Registrants from throughout the nation and from several foreign countries are expected again this season, and the Seminar schedule has been arranged to permit ample time for recreation.

The Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology will be a midweek feature, to which all registrants are invited. It will be held on Wednesday afternoon, January 20, and will be followed at 8 p.m. by the usual informal banquet, at which a distinguished guest speaker will be presented. All registrants of the Seminar and their wives are privileged to attend.

On January 18, 19 and 20, the lectures on Ophthalmology are scheduled. The lecturers and their subjects are: Dr. W. Banks Anderson, Durham, N. C., "Retinal Lesions as a Manifestation of Systemic Disease," and "Uveal Manifestations of Systemic Disease;" Dr. William P. Beetham, Boston, "The Anterior Ocular Segment in Diabetes Mellitus," "Keratopathies and Diminished Lacrimal Secretion," and "Ocular Changes in Endocrine Diseases;" Dr. William C. Owens, Baltimore, "Present Status of Retrolental Fibroplasia," and "Practical Analysis and Management of Vertical Deviations;" Dr. Algernon B. Reese, New York City, "The Diagnosis and Treatment of Diseases Affecting Infants and Children," "The Diagnosis and Treatment of Complications Following Cataract Extraction," and "The Treatment of Certain Tumors Encountered in Ophthalmology;" and Dr. Maynard C. Wheeler, New York City, "The Examination of the Strabismus Patient," "The Medical Treatment of Strabismus," and "The Surgical Treatment of Strabismus."

The lectures on Otolaryngology will follow on January 21, 22 and 23. The lecturers and their subjects are: Dr. Edwin N. Broyles, Baltimore, "Tracheotomy," "Technique of Endoscopy," and "Visual Aids to Endoscopy and Visual Aids in Examination of the Nose and Nasopharynx;" Dr. Howard P. House, Los Angeles, "Surgical Management of the Obstructed Nose," "Closure of a Post-auricular Fistula," "Congenital and Acquired Ear Canal Atresia," and "Surgical Management of Meniere's Syndrome," all four illustrated by motion pictures, and "Common Hearing Problems and Office Management;" Dr. W. J. McNally, Montreal, Canada, "The Diagnosis and Treatment of Dizziness," "A Clinician's Approach to Nerve Deafness," and "Practical Vestibular Tests and Their Interpretation;" Dr. Dorothy Wolff, New York City, "Reading a Complete Series of Temporal Bone Sections Cut Horizontally, for Normal Anatomy. Contrasting the Normal with the Mate Which Has Atresia of the External Auditory Canal," "Reading a Few Sections Through Important Areas, Cut Vertically at Right Angles to the Long Axis of the Petrosa. Reading Cases of Acute and Chronic Otitis Media, Cut in the Same Plane as the Normal," and "The Comparative Anatomy of the Cochlear Aqueduct;" and Dr. DeGraaf Woodman, New York City, "Laryngeal Paralysis with Emphasis on Bilateral Abductor Paralysis," "Laryngeal Stenosis: New Technique for Correcting Same Together with Various Adaptations of the McNaught Tantalum Keel Technique," and "Discussion of the Use of Various Function-Preserving Techniques in Laryngeal Cancer Surgery," all three illustrated.

The New Orleans Graduate Medical Assembly

The Seventeenth Annual Meeting of The New Orleans Graduate Medical Assembly will be held March 8-11, 1954, with headquarters at the Municipal Auditorium.

Eighteen outstanding guest speakers will participate, and their presentations will be of interest to both specialists and general practitioners. The program will include 54 informative discussions on many topics of current medical interest, in addition to clinicopathologic conferences, symposia, three dimensional surgical motion pictures, round-table luncheons and technical exhibits.

The Assembly has planned another interesting postclinical tour to follow the 1954 meeting in New Orleans. On Sunday, March 14, the group will leave Los Angeles via Pan American World Airways, and accommodations have been secured at the Royal Hawaiian Hotel in Honolulu, Island of Oahu.

After an interesting sightseeing schedule, the group will leave on Wednesday, March 17, for the Island of Kauai, where reservations have been made at the Kauai Inn. Visits will also be made

to Hilo and the Kona Coast. The party will return to Honolulu for several days prior to sailing on the S. S. Lurline on Thursday, April 1. Arrangements have been made for visits to hospitals and for various medical programs.

Details of the New Orleans meeting and the postclinical tour are available at the office of the Assembly, Room 103, 1430 Tulane Avenue, New Orleans 12.

STATE BOARD OF HEALTH

All Physicians' Fees in State Cancer Program Discontinued

When the State Board of Health Cancer Program was started in 1947, the funds appropriated by the legislature were adequate to cover the program. It was believed then that the physicians who took care of the indigent patients should be paid; however, some physicians did not agree with the idea. Many physicians gave the necessary medical or surgical service to the indigent patients, but refused to accept fees from the state. These physicians are to be commended for their belief and action in wanting to see that the indigent in their community are given the necessary medical or surgical care for which no remuneration is expected .

Funds appropriated by the legislature were used for diagnostic procedures, hospitalization of patients in early stages of the disease, clerical or nursing assistance at the tumor clinics, and some physicians' fees. Funds were also used for the Annual State Cancer Seminars as well as the Cross Roads Seminars and educational films and material.

As the cancer case load grew from year to year, it became necessary to curtail some phases of the program to keep within the budget provided by the legislature. First the physicians' fees were reduced 50 per cent; then in 1951 all physicians' fees were discontinued except the fees to radiologists and anesthesiologists.

In September 1953, all fees to radiologists were discontinued and, effective Nov. 1, 1953, the fees to all physicians, including the anesthesiologists, were discontinued. Fees for diagnostic procedures such as roentgen examination and blood tests are still paid, but on a reduced scale. Each of these curtailments was necessitated by progressive growth of the volume of the program without any corresponding increase in funds for its administration.

In each step in the cancer program the Florida Cancer Council has met and discussed the problems and made certain recommendations. The recommendations of the Cancer Council have been accepted by the State Board of Health and the American Cancer Society and carried out where practical.

At the Florida Cancer Council meeting in Miami Beach, Oct. 18, 1953, the following motion was made and passed: "That the fees to physicians now being paid by the Cancer Society and State Board of Health be discontinued. The purpose of this resolution is primarily in the interest of the physician-patient relationship."

The purpose of the State Cancer Program has been to help provide diagnostic facilities and treatment for the early indigent cancer patient. The experience gained and the learning acquired by those physicians who take part in the tumor clinics is most valuable.

At the present time all state-appropriated funds are being used only for diagnostic procedures in the tumor clinics, hospitalization of patients, and some clerical and nursing service in the tumor clinics. The American Cancer Society, Florida Division, helps to finance the clerical assistance in some of the tumor clinics as well as to furnish supplies and equipment for the clinics and travel for patients when necessary. The State Cancer Society also financed the majority of the expenses of the Cross Roads Cancer Seminars conducted over the state this fall.

Inquiries made at the national headquarters of the American Cancer Society and in other states indicate that no fees are being paid to the physicians who take part in the cancer programs of other states. This information has been confirmed by the American College of Surgeons' representative, and there are only two or three states that do provide an honorarium to their physicians.

The purpose of this article, which has been prepared by members of the Florida Cancer Council, is to keep the physicians in Florida advised of the developments in the Florida Cancer Program.

The Editor Invites Your Contributions on Data of Notable Interest

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BIRTHS AND DEATHS

Births

Dr. and Mrs. William J. Knauer Jr. of Washington, D. C., announce the birth of a son on Sept. 18, 1953.

Dr. and Mrs. Samuel B. Kleinman of Miami Beach announce the birth of a son, Paul, on Oct. 1, 1953.

Dr. and Mrs. Richard G. Skinner Jr. of Jacksonville announce the birth of a son, Richard Greene III, on Oct. 17, 1953.

Deaths — Members

Pearlman, S. Joseph, Miami Beach ..... Oct. 6, 1953
Thames, Rufus, Milton ..... Oct. 26, 1953

Deaths — Other Doctors

Crane, Edward M., Hardwick, Vt. ..... Sept. 4, 1946
Mills, John H., Portland, Ore. ..... Oct. 14, 1951
Wilson, James I., Ochlochnee, Ga. ..... Jan. 29, 1952
Charlton, H. Richard, Daytona Beach ..... May 14, 1953
Webb, Roy, Delray Beach ..... July 18, 1953
Weiss, Charles, Miami Beach ..... July 26, 1953
Remington, Alvah C., Rochester, N. Y. ..... Aug. 17, 1953

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Baehr, John J., Pensacola
Belyeu, Jesse H., Jacksonville
Dornberger, George R., Fort Lauderdale
Gillespie, Russell H. D., Jacksonville
Hardin, Henry C. Jr., Miami
Herring, Howard E. Jr., Pensacola
Jackson, Truxton L., Miami
Kirkley, William H., Fort Lauderdale
Leonard, James B., Clearwater
Mendenez, Raymond, Miami
Miller, William W. Jr., Pensacola
Talley, Robert G., Fort Lauderdale
Warrington, James C., Perrine
Williams, Salvador A., Canal Point
Wrubel, Norman N., Hollywood

Medical Officers Returned

Dr. Ira K. Brandt, who entered military service on May 11, 1953, was released from active duty on Sept. 18, 1953 with the rank of captain (U. S. Army). His address is 1535 Sunset Dr., Coral Gables.

Dr. Robert M. Lee, who entered military service on July 16, 1951, was released from active duty on July 21, 1953, with the rank of captain (U.S.A.F.). His address is 333 N. E. 86th St., Miami.

Dr. John S. Cowdery, who entered military service on Nov. 1, 1952, was released from active duty on Sept. 25, 1953 with the rank of lieutenant (U. S. Navy). His address is 1521 Margaret St., Jacksonville.

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P.O. Box 1018, Jacksonville, Fla.

Name .....
(Please print)

Old Address:

Street .....
City & Zone .....
State .....

New Address

Street .....
City & Zone .....
State .....

STATE NEWS ITEMS

Officers of the Florida Pediatric Society elected at the meeting in Miami in October are Drs. C. Jennings Derrick, West Palm Beach, president; Lewis T. Corum, Tampa, vice president; and Wesley S. Nock, Coral Gables, secretary-treasurer. Drs. Charlotte C. Maguire of Orlando and J. K. David Jr. of Jacksonville were elected to the executive committee.

Dr. Morris B. Seltzer of Daytona Beach attended a Medical Alumni Association meeting at the University of Toronto and the Graduate Fortnight of the New York Academy of Medicine in October.

Dr. Turner E. Cato of Miami has been named chairman of the Public Health Advisory Committee of the Dade County Tuberculosis Association.

Dr. Robert D. Higgins of Daytona Beach, first vice president of the Florida Public Health Association, presided over the second general session of the annual meeting of the group in Tampa in October. He also participated in a panel discussion on mental health.

Dr. Rollin D. Thompson of Coral Gables is heading the Medical Advisory Committee for 1953-54 of the Dade County Tuberculosis Association. Serving on Dr. Thompson's committee are Drs. DeWitt C. Daughtry, Nelson T. Pearson, Isaac B. Cippes and Robert A. McNaughton of Miami and Maurice Kovnat of Miami Beach.

Dr. Joseph L. Akerman of Apopka at an October meeting of the Apopka Rotary Club, reviewed an article on the danger of drugs as a Communist weapon.

Dr. Milton S. Saslaw of Miami was guest speaker at the annual board meeting of the Heart Association of Palm Beach County in October.

Dr. A. Louis Girardin Jr. of Fort Myers attended the International Congress of Pediatrics in Havana, Cuba, in October.

Dr. Frank G. Slaughter of Jacksonville addressed an opening session of the Southern Medical Association Convention in Atlanta on October 26. A condensation of his talk about St. Luke "The Beloved Physician," is on page 407 of this Journal.

Dr. Joseph Halton of Sarasota has returned to his practice after completing a postgraduate course at the Pratt Diagnostic Clinic in Boston.

Dr. Russell B. Carson of Fort Lauderdale was made an honorary member of the south central section of the American Urological Association during the annual meeting of the group in Kansas City, Mo., in October.

Dr. Edmund P. Kelley of Sarasota was guest speaker at a regular monthly meeting of the Alpha Iota Chapter of Epsilon Sigma Alpha held in that city in October. Dr. Kelley spoke on "Blood Types."

Dr. Hugh G. Reaves of Sarasota was elected president of the Florida Division of the American Cancer Society at the recent meeting in Miami. Dr. Reaves and Dr. C. Frank Chunn of Tampa were presented awards for meritorious service.

Dr. George F. Schmitt Jr. of Miami spoke at the regional meeting of the American College of Physicians at Sea Island, Ga., on "The Milliequivalent in Clinical Practice."

Dr. Wayne B. Martin of Coral Gables entered medical service with the U. S. Navy on Aug. 15, 1953.

Dr. Joseph J. Lowenthal of Jacksonville has returned to his practice after attending a short course in Chicago in October. The course was under the auspices of the American College of Physicians.

Drs. Newton C. McCullough and Charlotte C. Maguire of Orlando took part in a Countywide Cerebral Palsy Clinic sponsored by the Florida Crippled Children's Commission in Welch on October 2.

Dr. Frank L. Quillman, formerly of Sanford, who was Seminole County Health Officer, was honored by the Sanford Lions Club for his "unselfish and devoted services to the residents of Seminole County as Health Officer." Dr. Quillman resigned to accept a job as health official in Champaign, Ill.

Dr. Bowman W. Branning of Miami was named one of the seven Women of Achievement by the Federation of Business and Professional Woman's Clubs of that city. She was honored at a banquet culminating Business Women's Week on October 17.

Drs. Franz H. Stewart and Scheffel H. Wright of Miami took part in a panel discussion on cardiovascular diseases before the Miami Exchange Club.

Dr. Ralph W. Jack of Miami, president of the Dade County Medical Association, welcomed the students at Jackson Memorial Hospital with a brief talk as the University of Miami School of Medicine launched its second year of existence in September.

Dr. Cullen W. Banks II (Col.) of Gainesville entered medical service with the U. S. Army on May 27, 1953, with the rank of first lieutenant.

Dr. J. K. David Jr. of Jacksonville took part in a Seminar on Hematology at the annual meeting of the American Academy of Pediatrics in Miami in October.

Drs. Lawrence E. Geeslin, Louie Limbaugh and Robert H. Nickau of Jacksonville attended a short course under the auspices of the American College of Physicians held in New York City in October.

Dr. Duncan T. McEwan of Orlando spoke at a meeting of the officers and members of the Woman's Auxiliary to the Orange County Medical Society on November 5.

Dr. Francis A. Reed of Miami Beach spoke on 'The Complex Electrocardiogram" at a medical meeting at St. Simon's Island, Ga., in October.

Dr. Joseph H. Lucinian of Miami has returned to his practice after attending a meeting of the Roentgen Ray Society in Cincinnati. He also spent several days in observation and study at the Radioisotope Laboratory of the Bowman Gray School of Medicine in Winston-Salem, N. C.

The following Association members attended the American Academy of Pediatrics Annual Meeting in Miami, October 6-9: Drs. Wilbert O. Norville (Col.), Belle Glade; Gunnard J. Antell, Ira K. Brandt, Philip J. Chastain, Wesley S. Nock, Warren W. Quillian, Karl W. Vetter and Hillard W. Willis, Coral Gables; Bennett J. LaCour Jr., and Ludo von Meysenbug, Daytona Beach; James M. Weaver, Fort Lauderdale; Raymond S. Camp, Gainesville; Robert R. Harriss, Russell R. Hippensteel and Frances E. M. Read, Hollywood; Cornelia M. Carithers, Hugh A. Carithers, J. K. David Jr., Thomas M. Palmer and Robert B. Ragland, Jacksonville; James R. Boulware Jr., Fred S. Gachet and William S. Johnson, Lakeland; Maurice Blinski, Gerard F. Carter, Maurice M. Greenfield, James J. Griffitts, Erna K. Klass, Simon M. Lipton, George Lister, Wm. W. McKibben, Isidore Marx, Robert F. Mikell, Samuel J. Roberts, Charles Rosenfeld, Ruth W. Rumsey, Irving Stemerman, Phyllis P. Vaughn and Lynn W. Whelchel, Miami; Howard A. Engle, Elias Freidus, Robert J. Grayson, Leo Grossman, Lewis L. Julien, Harry Kaufman, George N. Leonard, Meyer B. Marks, and Stanley E. Schwartz, Miami Beach; Ralph E. Baxter and Robert A. Mayer, Miami Shores; Harry M. Edwards, Ocala; George W. Griffin, Charlotte C. Maguire, John D. McKey and Andrew W. Townes Jr., Orlando; John J. Benton, Panama City; Charles R. Benton, and Franklin L. DeBusk, Pensacola; George C. Hopkins Jr., St. Augustine; Sidney Grau and Councill C. Rudolph, St. Petersburg; Henry G. Morton, Sarasota; Ernest W. Ekermeyer and George S. Palmer, Tallahassee; Leo Batell, Lewis T. Corum. Douglas D. Martin and James M. San, Tampa; Richard M. Irwin, Lawrence R. Leviton, W. Ambrose McGee, David W. Martin and Edgar W. Stephens, West Palm Beach.

Dr. Lorenzo L. Parks of Jacksonville gave a talk on "Development of Local Health Services in Florida" at a meeting of the Meninak Club in September.

Dr. Leo M. Wachtel of Jacksonville spoke on the expansion program of St. Vincent's Hospital before the Auxiliary of the Hospital in October.

Dr. Carl C. Mendoza of Jacksonville has been appointed to a term on the Florida State Board of Health by Acting Governor Charley E. Johns.

Dr. Thomas J. Stewart of Century entered medical service with the U. S. Army on Oct. 14, 1953, with the rank of first lieutenant.

Dr. Hawley H. Seiler of Tampa has been appointed to the National Advisory Committee of the American Trudeau Society, Medical Section of the National Tuberculosis Association.

The State Medical Journal Conference sponsored by the State Journal Advertising Bureau was held in Chicago November 9 and 10. Representing the Florida Medical Journal at the meeting was Ernest R. Gibson, Jacksonville, managing editor. This Conference is held biannually. Editorial work and advertising were discussed for the purpose of improving the publications.

Drs. Andrew J. Jesacher and Edward M. Langer of Sarasota were among 88 physicians from throughout the nation who attended a special postgraduate course on "Physiological Basis of Internal Medicine" at Duke University.

Dr. Leo Grossman of Miami Beach was speaker at the monthly discussion group meeting of Lorber Chapter, National Home for Jewish Children at Denver. His topic was "Behavior Problems of Children."

Announcing The Seventeenth Annual Meeting of

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Conference Headquarters - Municipal Auditorium - March 8 - 11, 1954

GUEST SPEAKERS

Perry P. Volpitto, M.D., Augusta, Ga.
Anesthesiology

Earl D. Osborne, M.D., Buffalo, N. Y.
Dermatology

Julian M. Ruffin, M.D., Durham, N. C.
Gastroenterology

Allan C. Barnes, M.D., Cleveland, O.
Gynecology

Walter C. Alvarez, M.D., Chicago
Internal Medicine

William D. Stroud, M.D., Philadelphia
Internal Medicine

Lawrence C. Kolb, M.D., Rochester, Minn.
Neuropsychiatry

Nicholson J. Eastman, M.D., Baltimore
Obstetrics

A. D. Ruedemann, M.D., Detroit
Ophthalmology

Oscar L. Miller, M.D., Charlotte, N. C.
Orthopedic Surgery

Francis L. Lederer, M.D., Chicago
Otolaryngology

Emmerich von Haam, M.D., Columbus, O.
Pathology

Philip M. Stimson, M.D., New York
Pediatrics

Ira H. Lockwood, M.D., Kansas City, Mo.
Radiology

Brian Blades, M.D., Washington, D. C.
Surgery

Samuel F. Marshall, M.D., Boston
Surgery

Orvar Swenson, M.D., Boston
Surgery

Charles D. Creevy, M.D., Minneapolis
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MARCH 14 — April 6

For information concerning the Assembly meeting and the tour write
Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

The Florida Medical Association's fair exhibit was shown for the fourth time Oct. 19-25, 1953, at the Pensacola Interstate Fair, Pensacola, under sponsorship of the Escambia County Medical Society. This showing increased to 17,756 the actual number of persons passing through the exhibit.

Previously the exhibit had been shown by the Association at the Florida State Fair in Tampa. The Leon - Gadsden - Liberty - Wakulla-Jefferson County Medical Society sponsored it at the North Florida Fair in Tallahassee and the Orange County Medical Society at the Central Florida Exposition at Orlando.

Dr. Walter C. Payne Sr., Pensacola, chairman of the Committee on Public Relations for the Escambia County Medical Society, supervised the show at the Fair there. Cooperating as a courtesy to the Society in offering free blood typing and blood pressure determinations were the Escambia County Blood Bank, Sacred Heart Hospital, Baptist Hospital and Escambia General Hospital. The two services were offered from 7 to 10 p.m. each day excepting Sunday. A total of 512 persons had their blood typed and 1,055 their blood pressure determined.

Fair officials stated that approximately 90,000 persons attended the event and saw the exhibits housed in buildings and circus tents. The medical exhibit was bounded by displays of farm products sponsored by various 4-H Clubs.

All radio stations in Pensacola publicized the exhibit with spot announcements the week preceding and during the Fair. Local newspapers carried a picture of the exhibit and several stories.

Technicians doing blood typing were assisted by members of the Woman's Auxiliary to the Escambia County Medical Society. Assisting Dr. Payne were the members of his Committee, Dr. Alvyn W. White and Dr. Stanley G. Childers; Dr. Alvin L. Stebbins, president of the Society, and Dr. Paul F. Baranco, secretary.

Dr. Turner E. Cato of Miami was the official representative of the Florida Medical Association's Committee on Child Health at the Fourth National Conference on Physicians and Schools held at Highland Park, Ill., September 30-October 2.

Dr. Charles N. Stevens (Col.) of Fort Myers entered medical service wth the U. S. Army on July 4, 1952, with the rank of first lieutenant.

(Continued on page 424)

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

LOST: One old gold earring with small diamond during Annual Convention Hollywood Beach Hotel. Very valuable to owner. Reward. Write William H. Grace, M.D., 71 First Street, Fort Myers, Fla.

WANTED: Association with group, industry, institution; Fort Lauderdale area. Clinical and administrative experience. Write 69-98, P. O. Box 1018, Jacksonville, Fla.

LOCATION: Established thirty year EENT lucrative practice for sale. Would rent office with or without equipment. One block from ocean. Write L. W. Glatzau, M.D., 530 North Grandview, Daytona Beach, Fla.

WANTED: M.D. for general practice in Mulberry, Fla. Address all inquiries to the City Council, Mulberry, Fla.

GENERAL PRACTITIONER: 29, Florida license, getting out of Navy December, wishes to join group practice. Write 69-101, P. O. Box 1018, Jacksonville, Fla.

NOTICE: Laboratory facilities available for diagnostic tests for virus and bacterial diseases at the Clinical Laboratory of Hollywood Hospital, 1859 Van Buren Street, Hollywood, Fla.

POSITION OPEN: With West Coast Group for Certified or Qualified Orthopedist. Age 40 years or less. Write 69-102, P.O. Box 1018, Jacksonville, Fla.

RADIOLOGIST: Board certified diagnosis and therapy; age 38, draft exempt, married with family; consider good opportunity for hospital or office practice or combination. Write 69-103, P.O. Box 1018, Jacksonville, Fla.

SITUATION WANTED: Physician, age 33, married, Florida license. Two years postgraduate training, six years general practice, qualified to do obstetrics. Desires partnership or group practice; prefers coastal town. Write 69-104, P. O. Box 1018, Jacksonville, Fla.

FOR RENT: New modern office. Air Conditioned. Near hospital. St. Petersburg. Write 69-105, P. O. Box 1018, Jacksonville, Fla.

SURGEON: Age 39, F.A.C.S. and Board Eligible, seeking association with older surgeon, or community in need of a well trained general surgeon. Write 69-106, P. O. Box 1018, Jacksonville, Fla.

FOR SALE: Well establishd Ob-Gyn practice in Fort Lauderdale. Take over at once. For details write: O. B., Box 1234, Fort Lauderade, Fla.

TO RENT: Modern office building, x-ray and all diagnostic equipment, splendid practice established since 1916. All communications welcomed and confidential; available December 15th; retiring for reason of ill health. G. H. Brantley, M.D., Box 1151, Lake Worth, Fla.

(The Council on Pharmacy and Chemistry of the American Medical Association has adopted the following statement which appears in New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, pp. 171-173, 1953.)

Methantheline Bromide.—*Banthīne Bromide (Searle)*

β-Diethylmethylaminoethyl 9-xanthenecarboxylate bromide

Actions and Uses.—Methantheline bromide, a parasympatholytic agent, produces the peripheral action of anticholinergic drugs such as atropine and the ganglionic blocking action of drugs such as tetraethylammonium chloride. Tolerated amounts of methantheline bromide exert side effects typical of atropine-like drugs, but cause less tachycardia, and also cause less postural hypotension than does tetraethylammonium chloride. Toxic doses produce a curare-like action at the somatic neuromuscular junction.

Clinical studies indicate that the drug effectively inhibits motility of the gastro-intestinal and genito-urinary tracts and, to a variable degree, diminishes the volume of perspiration and salivary, gastric, and pancreatic secretions. It also decreases mucoprotein secretion. Like atropine, it produces mydriasis and cycloplegia when applied locally to the eye or administered systemically, but until more clinical evidence becomes available, its local use for this purpose is not recommended. The value of the drug for preventing abnormal cardiac reflexes through the vagus during thoracic surgery, or as an agent for routine preoperative medication in place of atropine, requires further investigation before final conclusions can be reached.

Methantheline bromide is indicated for clinical use whenever anticholinergic spasmolytic action is desired, provided it is not contraindicated because of its atropine-like characteristics or because of a patient's intolerance to the unavoidable side effects of such therapy. It is useful as an adjunct in the management of peptic ulcer, chronic hypertrophic gastritis, certain less specific forms of gastritis, pylorospasm, hyperemesis gravidarum, biliary dyskinesia, acute and chronic pancreatitis, hypermotility of the small intestine not associated with organic change, ileostomies, spastic colon (mucous colitis, irritable bowel), diverticulitis, ureteral and urinary bladder spasm, hyperhidrosis or control of normal sweating which aggravates certain dermatoses, and control of salivation.

Methantheline bromide produces some degree of cycloplegia and mydriasis in therapeutic doses and therefore should not be administered to patients with glaucoma. It sometimes decreases the ability to read fine print. Xerostomia (dryness of the mouth) is a common, sometimes transient, side effect. Urinary retention of varying degrees may occur in elderly male patients with prostatic hypertrophy, and some patients may have difficulty emptying the rectum. Patients with edematous duodenal ulceration may experience nausea and vomiting during initial administration of the drug. These patients should take only liquids during the institution of drug therapy. All patients should be advised of the possible occurrence of side effects. Overdosage sufficient to produce a curare-like action may be counteracted by prompt subcutaneous injection of 2 mg. of neostigmine methylsulfate.

Dosage.—Methantheline bromide is administered orally or parenterally by either the intramuscular or intravenous route. Parenteral administration is not advised for patients able to take the drug orally. The average initial dose for adults, oral or parenteral, is 50 mg. For patients with considerable intolerance, 25 mg. may be employed. In the management of peptic ulcer, a beginning schedule of 50 mg. three times daily before meals, and 100 to 150 mg. on retiring is suggested. However, the usual effective dose is 100 mg. four times daily, although some patients may require more or less than this amount. The dosage may be increased to tolerance, using dryness of the mouth as a guide, and adjusted to meet the individual response of patients. Maintenance dosage in peptic ulcer is usually considered to be about one-half the therapeutic level. In the management of other hypermotile or hypersecretory states, the dosage should be adjusted to the smallest amount which will relieve the symptoms. When spastic conditions are secondary to inflammatory or other organic lesions, therapy directed toward the cause should be employed whenever possible.

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Tablets Banthīne Bromide: 50 mg.

(Continued from page 422)

Dr. Walter C. Payne Sr. of Pensacola has been elected first vice president of the Gulf Coast Clinical Society.

Dr. Theodore Norley of West Palm Beach spoke on the various phases of back injury as applied to workmen's compensation and liability cases at a meeting of the Palm Beach County Bar Association in October.

COMPONENT SOCIETY NOTES

Broward

The Broward County Medical Association has paid 100 per cent of its state dues for 1953.

Dade

At the regular monthly meeting of the Dade County Medical Association on November 3, Dr. Raymond E. Parks spoke on "Use of Radio-Active Iodine in the Diagnosis and Treatment of Diseases of the Thyroid."

Duval

At the regular meeting of the Duval County Medical Society on November 3, Drs. Wray J. Tomlinson, Jerome H. Newman, James C. Lanier Jr. and A. Sherrod Morrow took part in a symposium on "The Kidney."

Hillsborough

The Hillsborough County Medical Association met jointly with the Pinellas County Medical Society on November 3 in Tampa. Guest speaker was Dr. Richard Wesley TeLinde, Chief of Gynecological Surgery at Johns Hopkins Hospital and Professor of Gynecology of Johns Hopkins Medical School, who spoke on "New Concepts of Diagnosis and Treatment of Cervical Carcinoma, Including Non-invasive Carcinoma."

The Hillsborough County Medical Association has paid 100 per cent of its state dues for 1953.

Lake

The new officers of the Lake County Medical Society are: Dr. J. Basil Hall, Tavares, president; Dr. George E. Engelhard, Leesburg, vice president; and Dr. James R. Hanson, Tavares, secretary.

Pinellas

Officers of the Pinellas County Medical Society for 1954 are Drs. Alvin L. Mills, St. Petersburg, president; Clyde O. Anderson, St. Petersburg, president-elect; H. Milton Rogers, St. Petersburg, first vice president; John T. Karaphillis, Clearwater, second vice president; and Whitman C. McConnell, St. Petersburg, secretary-treasurer.

The Pinellas County Medical Society has paid 100 per cent of its state dues for 1953.

Meetings of the Pinellas County Medical Society will be held on the first Monday of each month during the coming year.

The November meeting of the Society was held jointly with the Hillsborough County Medical Association at the Floridan Hotel in Tampa. Dr. Richard Wesley TeLinde, Chief of Gynecological Surgery at Johns Hopkins Hospital and Professor of Gynecology at Johns Hopkins Medical School, spoke on "New Concepts of Diagnosis and Treatment of Cervical Carcinoma, Including Non-invasive Carcinoma."



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OBITUARIES

Edmonson Shorter Couric

Dr. Edmonson Shorter Couric of Miami died in a local hospital on Aug. 22, 1953, following an attack of coronary thrombosis 10 days previously. He was 62 years of age.

Dr. Couric was born in Eufaula, Ala., on June 5, 1891. He was graduated at the age of 22 from the Medical College of Alabama in Mobile and then served an internship in that city. He later had training in Chicago and New York hospitals. He began the general practice of medicine in Mt. Andrews, Ala., in 1916 and continued to practice in his native state for five years. For three of those years he was chief physician for the Woodward Iron Company of Birmingham.

In 1921 Dr. Couric located in Miami, where he continued to engage in the general practice of medicine in the Lemon City area. He was a member of the staff of Jackson Memorial Hospital for more than a quarter of a century and was a founder member of the recently opened North Dade Hospital, serving as chief of staff as well as president of the board of directors.

An ardent devotee of all sports, this pioneer Miami physician was also actively interested in local school affairs. For a number of years he was a trustee of the county school board. His school activities are attested by a plaque in his honor in the rotunda of Edison High School. He was a Mason and a member of Mahi Shrine Temple, and was a charter member and past president of the Little River Businessmen's Club. He held membership in the First Baptist Church.

Dr. Couric was a member of the Dade County Medical Association and was for 28 years a member of the Florida Medical Association. He also held membership in the Amercan Medical Association and was an early member of the American Academy of General Practice. For outstanding work in recent years on the treatment of black widow spider bites he won worldwide recognition.

In 1923 Dr. Couric was married to Mary Lee Wagner of Birmingham, who survives him. Other survivors include a daughter, Mrs. Richard L. Zaph of Washington, D. C.; a son, Edmonson S. Couric, Jr., a brother, J. B. Couric, and a nephew, William B. Couric, all of Miami; and a sister, Miss Pauline Couric of Eufaula, Ala.

Advertisement



From where I sit *by* Joe Marsh

One for the Books!

Noticed the Missus had a red ribbon tied around her finger at breakfast one morning last week. "What's that for?" I asked. "Memory slipping?"

"*It's not for me,*" she answers, "*it's to remind* you, *and everybody else who asks what it's for, to contribute to the Woman's Club Library Fund. We need $200 and we figured we'd get more help if we could get people to ask* us *about it.*"

Well, as it turned out, the red ribbon worked just fine. The ladies are having the library all fixed up—and there's enough money for some new books, too.

From where I sit, it would be a fine thing if we had some sort of private reminder when we forget the rights of others. Like when we start telling them how to practice a profession or what to choose for a beverage. I like a travel book and a temperate glass of beer—while you may prefer a cup of tea with a historical novel. But let's not "put the finger" on one another.

Joe Marsh

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BOOKS RECEIVED

The Physician in Atomic Defense: Atomic Principles, Biologic Reaction and Organization for Medical Defense. By Thad P. Sears, M.D., F.A.C.P. Pp. 308. Price, $6. Chicago, Year Book Publishers, Inc., 1953.

This book is the outgrowth of the author's conviction that the community in which he lived should be prepared for atomic warfare. Absorbing the fundamentals of atomic energy through study and special training, he set out to arouse civilians and professional colleagues alike from their unrealistic complacency and eventually put into brief and readable form the pertinent essentials of the physics of the atom and other basic information.

"The objective of this volume," as Dr. Sears put it, "is, first, to review briefly the present concepts of matter, gaining in this approach and without recourse to mathematical formulas, a sounder understanding of radioactivity, and its applications. Attention will next be given the structure of the atom; the significance of radioactivity; the chain reaction and the atomic bomb; the use of isotopes. Then the symptomatology, pathology and treatment of atomic bomb injuries and the methods of civil defense will be reviewed."

As pointed out in the foreword, whether one fears atomic assault from the air, whether one is layman or medical man, the atomic age is here with its industrial as well as wartime possibilities beyond calculation, and the educated man and woman in the street should endeaver to keep pace with the times. The increasing use of atomic energy for industrial purposes certainly means that the symptoms, pathology, prevention and treatment of radioactive effects become of immediate interest to all medical men and of special importance to the industrial physician and radiologist.

Heart and Circulation: Diagnosis and Treatment. By Meyer Sclar, M.D., F.A.C.C. Pp. 357. Price, $7.50. New York, Froben Press, Inc., 1953.

In this book, written especially for the general practitioner and the medical student, the commonly encountered cardiac conditions and their management are described. The basic concepts of diagnosis and treatment are presented in such a manner that both the physician and the student will find the approach to patients with cardiac disease greatly simplified. The rare and controversial concepts are also mentioned, but more briefly. In those instances in which opinions differ with regard to clinical and therapeutic procedures, the author has relied on his own clinical experiences, acquired in more than 30 years of active practice as a cardiologist.

There are two sections of the book. The 22 chapters of the first section deal with diseases of the heart. The second section with nine chapters covers diseases of the vascular tree.

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Workshop

The Workshop Plan is a plan to coordinate at the District Meetings information concerning Auxiliary affairs. When it was instituted two years ago, we believed in its future and knew its value well enough to establish it as a permanent procedure. We were, however, dubious of the name, "Workshop." Its connotation was humorously akin to "sweatshop," suggesting effort at a time formerly reserved for relaxation.

Mrs. James L. Anderson, then immediate past president, was the trail blazer. She covered the



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circuit as Madam P.R. (public relations) presiding at each District Meeting with contagious enthusiasm and set the standard, "new ground to be covered by Auxiliary."

With our Auxiliary stake in that new field, it but remained for the future vice presidents to hold court once a year in each district, offering an opportunity for all new Auxiliary ideas, questions, problems and aspirations to be considered, discussed and shared.

The progress of this annual affair has certainly exceeded our expectations. Its popularity was established by the response and attendance, and its value proved in the resulting state-wide planning which develops from close association and a common aim.

If the discussions which take place at these gatherings are recorded and the resulting conclusions coordinated, "Workshop" will become an effective supplement to the annual board meeting which takes place in November and will greatly enhance the production of each year.

Mrs. C. Robert DeArmas

Cook County Graduate School of Medicine

POSTGRADUATE COURSES

SURGERY—Intensive Course in Surgical Technic, Two Weeks, starting January 18, February 1, February 15, 1954. Surgical Technic, Surgical Anatomy & Clinical Surgery, Four Weeks, starting March 1, 1954. Surgical Anatomy & Clinical Surgery, Two Weeks, starting March 15, 1954. General Surgery, Two Weeks, starting April 26, 1954. Surgery of Colon & Rectum, One Week, starting March 1, 1954. Fractures & Traumatic Surgery, Two Weeks, starting March 1, 1954.

GYNECOLOGY—Intensive Course, Two Weeks, starting February 15, 1954. Vaginal Approach to Pelvic Surgery, One Week, starting March 1, 1954.

OBSTETRICS—Intensive Course, Two Weeks, starting March 1, 1954.

MEDICINE—Electrocardiography & Heart Disease, Two Weeks, starting March 15, 1954. Gastroscopy, Two Weeks, starting March 8, 1954. Two-Week Intensive Course starting May 3, 1954.

DIAGNOSTIC X-RAY—Clinical Course every week by appointment.

CYSTOSCOPY—Ten-day practical course starting every two weeks.

UROLOGY—Two-Week Intensive Course starting April 19, 1954.

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14. Can be used in high-calorie diets.

15. Useful in the dietary management of celiac disease.

16. Useful in the dietary management of idiopathic non-tropical sprue.

17. Useful in the management of diabetic diets.

18. Valuable in many allergy diets.

19. Belongs among foods useful in certain acute intestinal infections.

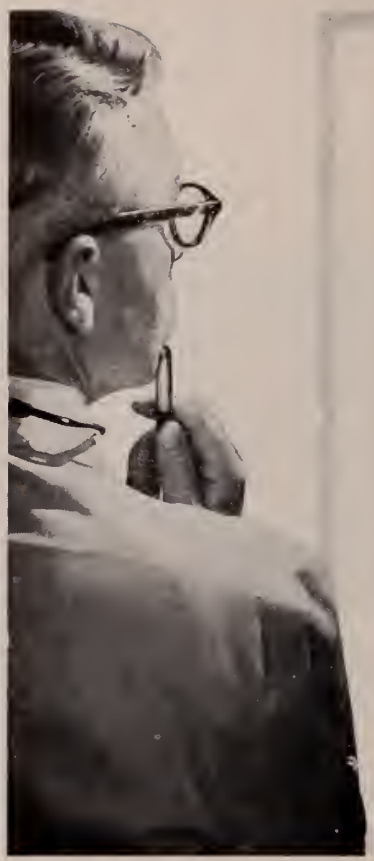
20. A protein sparer.

21. Favorably influences mineral retention.

22. Useful in the management of ulcer diets.

23. One of the easiest foods to eat or prepare.

FOR THE NAME OF THIS FOOD, PLEASE TURN THE PAGE



The answer is

B A N A N A S

If you would like

1. The authority for any of the statements made on the preceding page . . .
2. Additional information in connection with any of them...
3. The composition of the banana . . .
4. The nutritional story of the banana . . .
5. Information on various ways to prepare or serve bananas.

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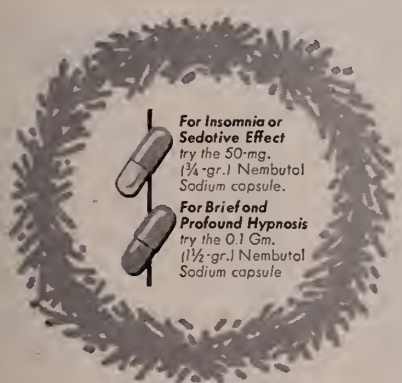
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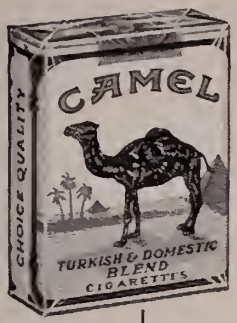
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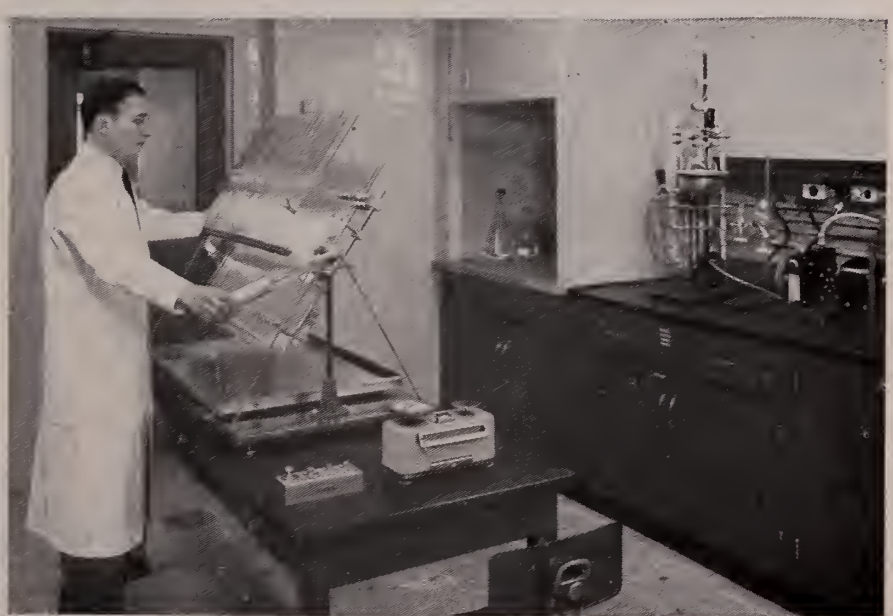
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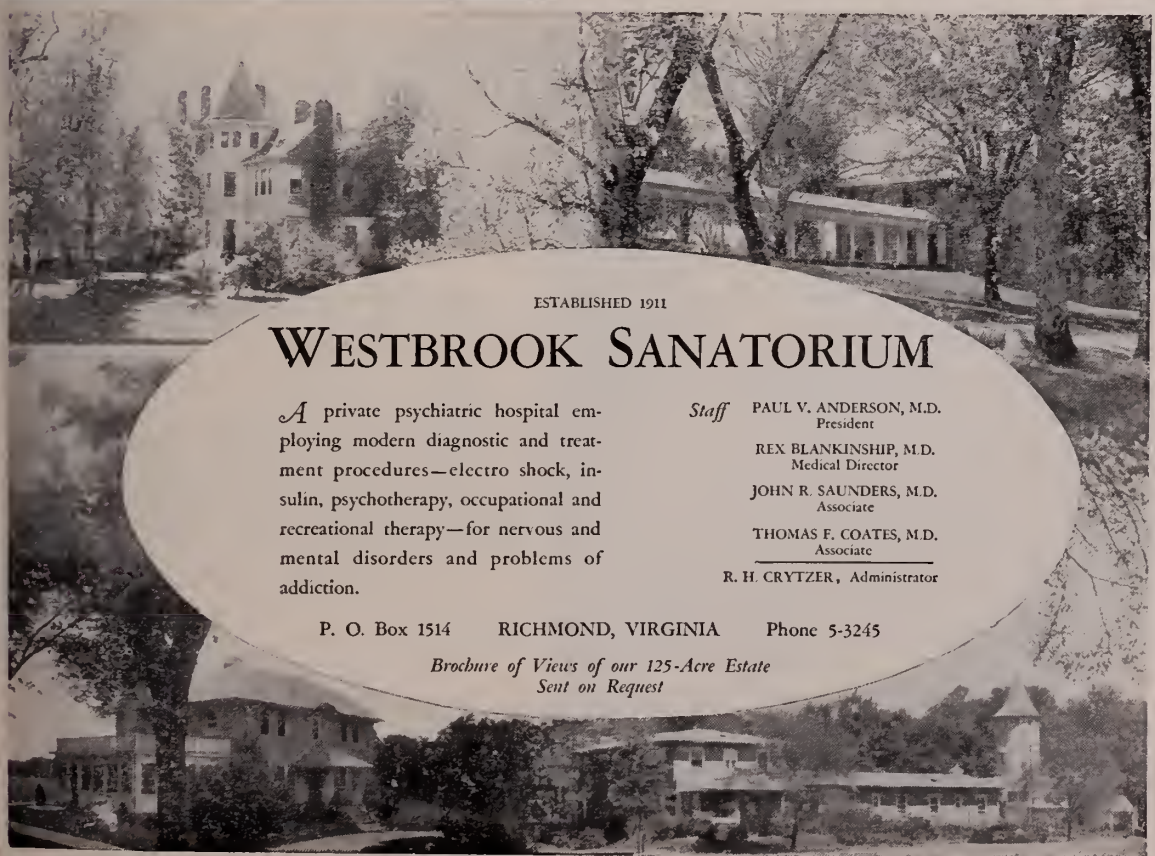
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ida Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
ida Medical Districts	John D. Milton, Miami	Council Chairman	
-Northwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
-Northeast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
-Southwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
-Southeast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
ida Specialty Societies			
demy of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	Hollywood, Apr. 25, '54
rgy Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
sthesiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
pter, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
m. and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
lth Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
ustrial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
rology & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
and Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	Orlando, Dec. 5-6, '53
thal. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	Hollywood, Apr. 25, '54
opedic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	" "
hologists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	" "
iatric Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
ctologic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	" "
iological Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
logical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
ida—			
asic Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
lood Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
lue Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	Miami, Dec. 3, '53
lue Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
ancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
linical Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
ental Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, April '54
eart Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
ospital Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	
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urses Association, State	Mrs. Mary Livingston, W. P. Beach	Mrs. Idalyn Lawthon, Tampa	
harmaceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
ublic Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
rudeau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	
uberculosis & Health Assn.	Leffie M. Carlton Jr., Tampa	Mrs. L. C. Conant, Fort Myers	St. Petersburg, Apr. 9-10, '54
oman's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers Jr., Cocoa	Hollywood, Apr. 25-27, '54
rican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	St. Louis, Dec. 1-4, '53
thern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
ama Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
rgia, Medical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
. Hospital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
theastern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
theastern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
theastern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
Coast Clinical Society	James N. Lockard, Pascagoula, Miss	F. C. Minkler, Pascagoula, Miss	

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	Escambia *Santa Rosa	Alvin L. Stebbins, M.D. 701 N. S St. Pensacola	Paul F. Baranco, M.D. 608 Blount Bldg. Pensacola	2nd Tuesday 8:00 P.M.	93	100%	
	Franklin-Gulf	Photis J. Nichols, M.D. Apalachicola	John W. Hendrix, M.D. Port St. Joe	Last Wednesday except Dec. & July	7	100%	A-1-54 Francis M. Watson, M.D. Marianna
	Jackson-Calhoun	Grayson C. Snyder, M.D. Floyd Bldg. Blountstown	Francis M. Watson, M.D. 120 Deering St. Marianna	1st Thursday 7:00 P.M. March, June, Sept., Dec.	18	100%	
	Walton-Okaloosa	Edgar H. Myers, M.D. DeFuniak Springs	William D. Cawthon, M.D. DeFuniak Springs	3rd Thursday 8:00 P.M.	17	100%	
	Washington-Holmes	L. H. Paul, M.D. Bonifay	Bayllye W. Dalton, M.D. Chipley		5	100%	
B	Columbia *Baker, Hamilton	Robert B. Harkness, M.D. 504 E. Duval St. Lake City	Thomas H. Bates, M.D. 27 W. Madison St. Lake City	1st Monday 7:30 P.M.	13	12	
	Leon-Gadsden-Liberty-Wakulla-Jefferson	Charles F. James Jr., M.D. Washington Sq. Bldg. Tallahassee	T. Bert Fletcher Jr., M.D. 516 N. Adams St. Tallahassee	Quarterly 7:30 P.M.	57	54	
	Suwannee	Hiram B. Curry, M.D. Jasper	Edward G. Haskell Jr., M.D. Branford	1st Saturday 9:30 A.M.	8	100%	A-2-55 George S. Palmer, M.D., Tallahassee
	Madison	Julian M. DuRant, M.D. Madison	A. Franklin Harrison, M.D. Madison		5	4	
	Taylor *Dixie, Lafayette	Mark E. Adams, M.D. Perry	Walter J. Baker, M.D. Foley	Last Friday 8:00 P.M.	4	100%	251
B	Alachua *Bradford, Gilchrist, Union	F. Emory Bell, M.D. Box 113 Gainesville	Glenn O. Summerlin, M.D. 209 N. E. 2nd Ave. Gainesville	2nd Tuesday 8:00 P.M.	48	46	
	Duval *Clay	W. W. Rogers, M.D. 313 Professional Bldg. Jacksonville	John T. Stage, M.D. 2033 Riverside Ave. Jacksonville	1st Tuesday 8:15 P.M.	265	256	
	Marion *Levy	Eugene G. Peek Jr.,M.D. Box 248 Ocala	Bertrand F. Drake, M.D. Box 326 Dunnellon	3rd Tuesday 7:00 P.M.	27	100%	B-3-54 William C. Thomas Jr., M.I Gainesville
	Nassau	David G. Humphreys, M.D. 113 N. 6th St. Fernandina	John W. McClane, M.D. Fernandina	Last Friday 8:00 P.M.	12	100%	
	Putnam	Bernard E. Kane, M.D. Box 216 Crescent City	James A. Long Jr., M.D. 1001 Main St. Palatka	2nd Tuesday 6:00 P.M.	9	100%	
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C	Brevard	Laurent L. LaRoche, M.D. 526 Brevard Ave. Cocoa	Allen E. Kuester, M.D. 501 Delannoy Ave. Cocoa	2nd Tuesday	26	25	
	Lake *Sumter	J. Basil Hall, M.D. Tavares	James R. Hanson, M.D. Tavares	1st Wednesday 7:30 P.M.	29	100%	B-4-55 Thomas C. Kenaston, M.D. Cocoa
	Orange *Osceola	G. Tayloe Gwathmey, M.D. 417 E. Robinson Ave. Orlando	Andrew W. Townes Jr., M.D. 717 N. Magnolia Ave. Orlando	3rd Wednesday 8:00 P.M.	171	100%	
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C	Hillsborough	Arthur R. Knauf, M.D. 706 Franklin St. Tampa	Julien C. Pate Jr., M.D. 1105 First Nat. Bk. Bldg. Tampa	1st Tuesday 8:00 P.M.	178	100%	
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	Pasco-Hernando-Citrus	Karl T. Humes, M.D. Box 157 Bushnell	W. Wardlaw Jones, M.D. Box 247 Dade City	2nd Thursday 7:00 P.M.	18	100%	C-5-55 Clyde O. Anderson, M.D St. Petersburg
	Pinellas	Alvin L. Mills, M.D. 308 Fla. Nat. Bk. Bldg. St. Petersburg	Whitman C. McConnell, M.D. 1517 4th St., N. St. Petersburg	1st Monday 6:00 P.M.	201	201	
	Sarasota	Cecil E. Miller, M.D. 880 S. Orange Ave. Sarasota	Melvin M. Simmons, M.D. 816 Florasota Gardens Sarasota	2nd Tuesday 8:30 P.M.	48	46	
D	DeSoto-Hardee-Highlands-Glades	Wesley S. Pyatt, M.D. Bowling Green	Merle C. Kayton, M.D. Wauchula	2nd Tuesday 8:00 P.M.	26	100%	
	Lee-Charlotte-Collier-Hendry	Ernest Bostelman, M.D. 201 Pythian Bldg. Fort Myers	Harry Fagan Jr., M.D. 310 Richards Bldg. Fort Myers	3rd Monday 7:30 P.M.	31	100%	C-6-54 Emmett E. Martin, M.D. Haines City
	Polk	Jere W. Annis, M.D. Box 1021 Lakeland	James T. Shelden, M.D. Box 1021 Lakeland	2nd Wednesday 7:00 P.M.	95	93	618
D	Indian River	John P. Gifford, M.D. 1625 Osceola Blvd. Vero Beach	William L. Fitts 3rd, M.D. Vero Beach Arcade Vero Beach	2nd Tuesday 8:00 P.M.	8	100%	
	Palm Beach	Graham W. King Jr., M.D. Box 505 Delray Beach	David A. Newman, M.D. 175 Bradley Pl. Palm Beach	3rd Monday 8:00 P.M.	130	100%	D-7-54 Erasmus B. Hardee, M.D. Vero Beach
	St. Lucie-Okeechobee-Martin	John T. McDermid, M.D. 337 N. 4th St. Fort Pierce	Adrian M. Sample, M.D. Box 897 Fort Pierce	3rd Thursday 8:00 P.M.	17	16	
	Broward	Claus A. Peterson, M.D. 312 Blount Bldg. Ft. Lauderdale	James M. Weaver, M.D. Box 4084 Ft. Lauderdale	4th Tuesday 8:00 P.M.	101	100%	
	Dade	Ralph W. Jack, M.D. 603 Dade C'wealth Bldg. Miami	Walter W. Sackett Jr., M.D. 603 Dade C'wealth Bldg. Miami	1st Tuesday 8:30 P.M.	650	626	D-8-55 Russell B. Carson, M.D. Fort Lauderda
	Monroe	Joseph L. G. Lester Jr., M.D. 422 Fleming St. Key West	Allen S. Shepard, M.D. 638 United St. Key West	2nd Thursday 8:00 P.M.	13	100%	919

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CONCLUSION

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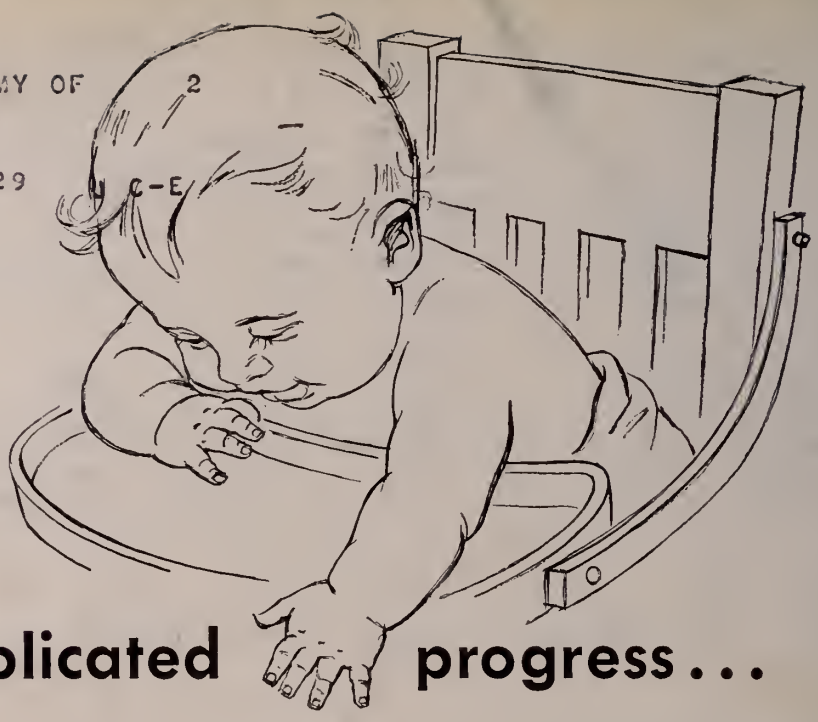
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1. Frost, L. H., and Jackson, R. L.: J. Pediat. 39: 585-592. 1951.



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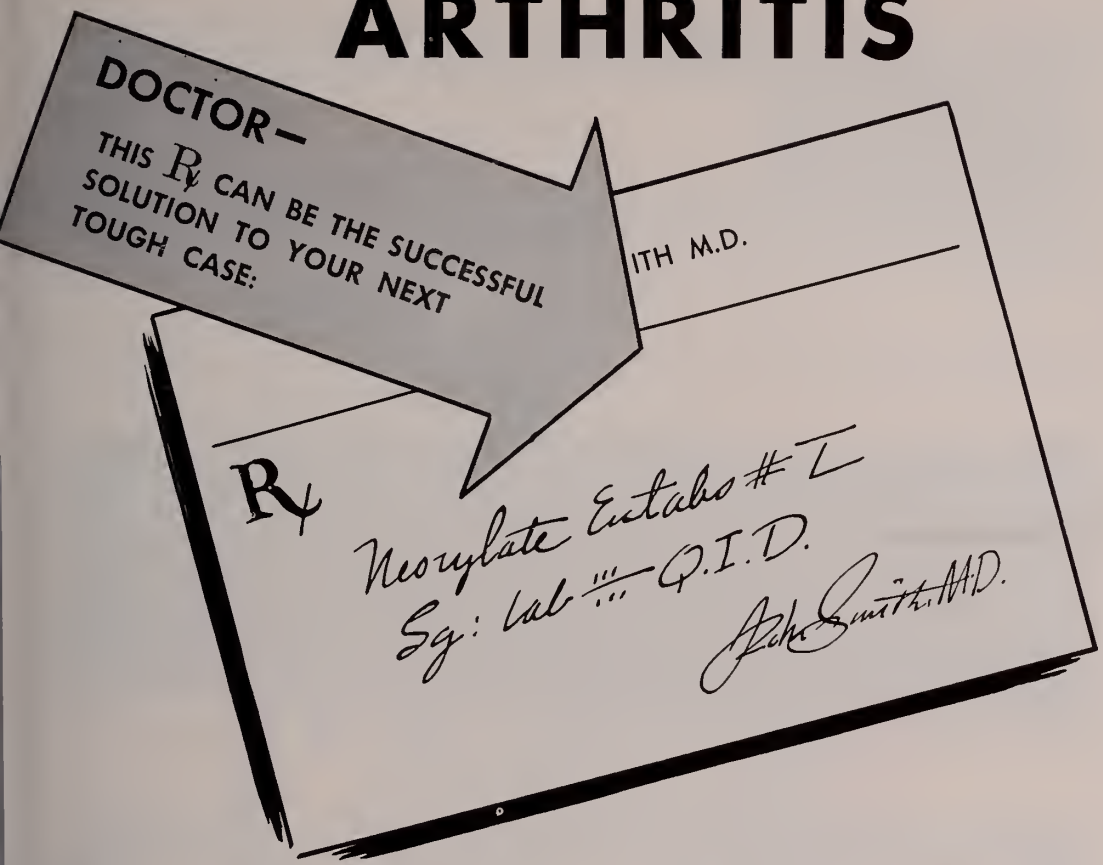
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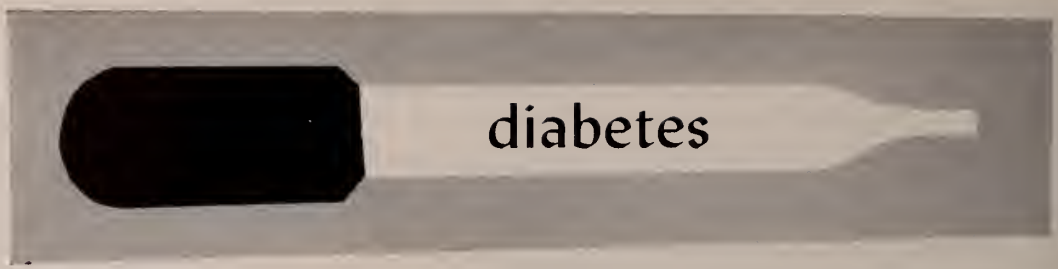
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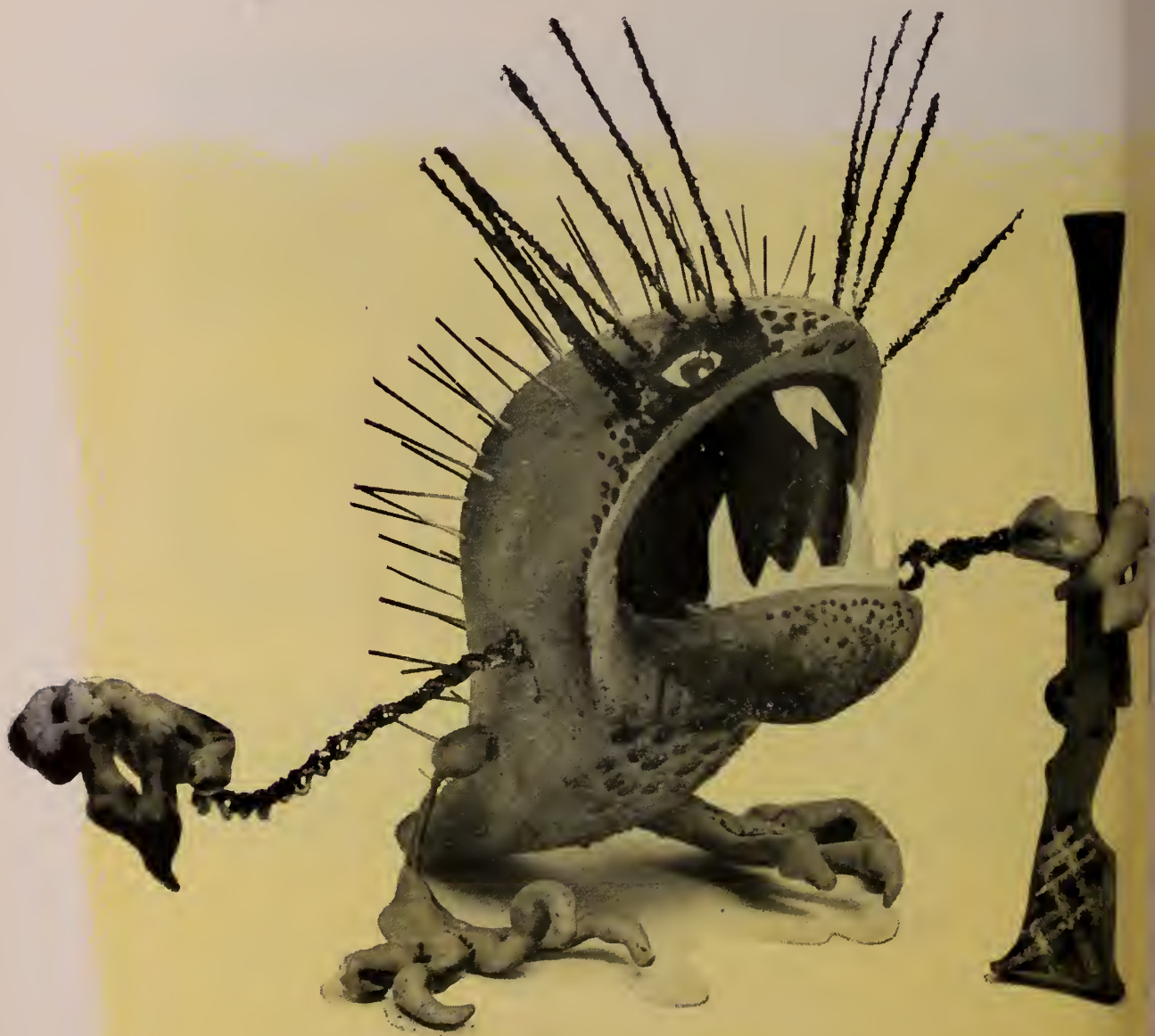
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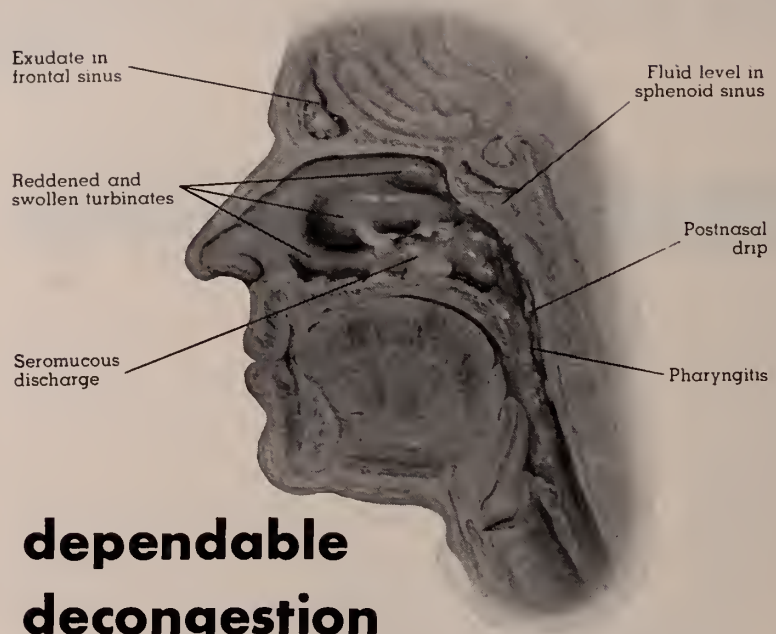
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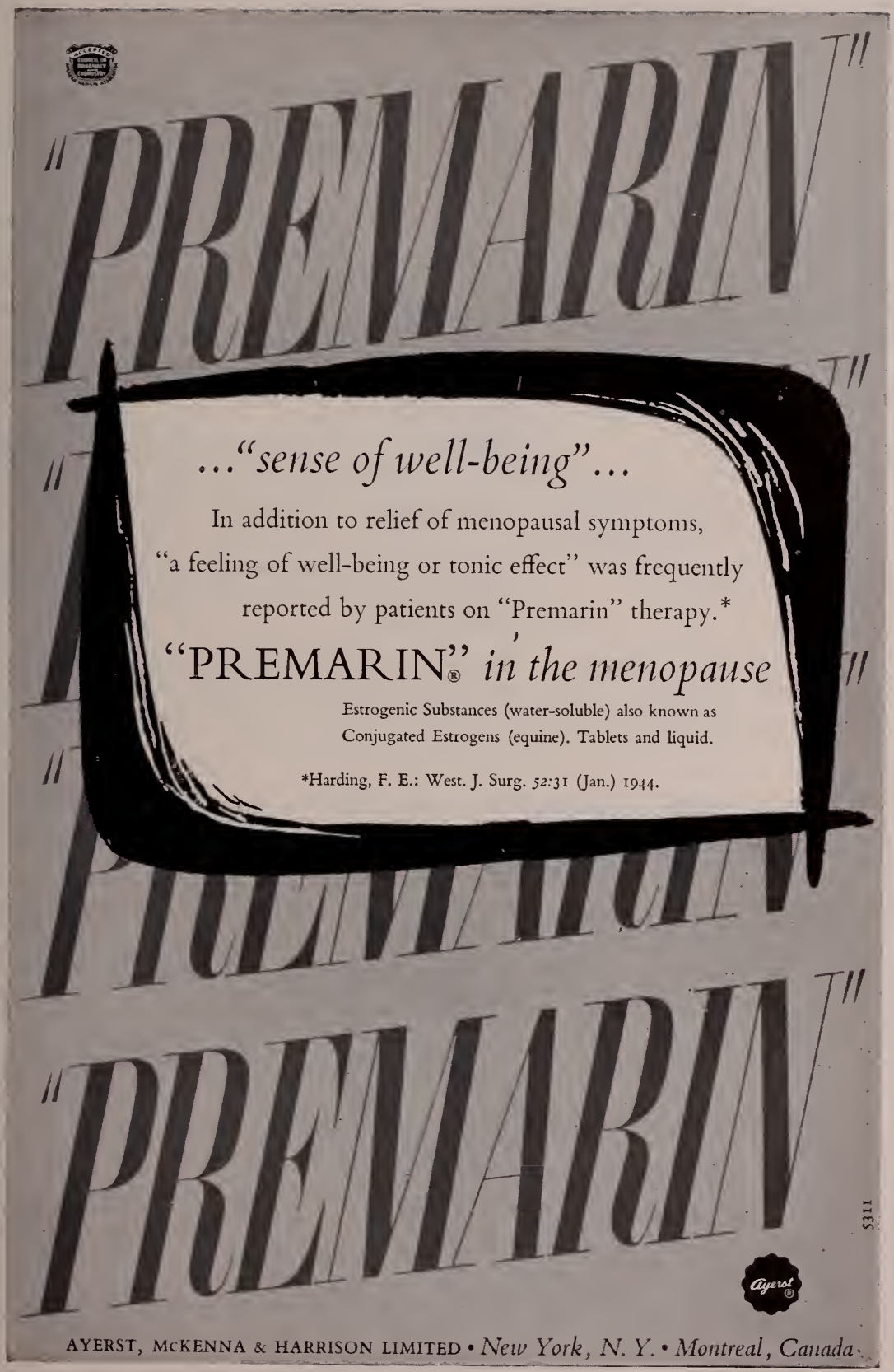
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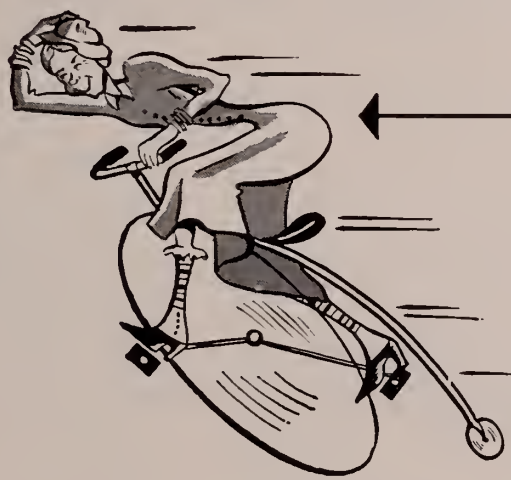
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Southern Florida and the Cardiac Patient

SIDNEY DAVIDSON, M.D.
LAKE WORTH

From the time of the Romans, it has been recognized that the more benign climate of the South had much to offer the sick. In the Old World, long before the discovery of the New World, it was the practice of those who could to spend as much of the winter as possible in Southern Europe. The sunny shores of the Mediterranean have long been used as a haven for the chronically ill of Europe who could escape the more inhospitable climate of the northern and central part of the continent.

In the New World, the first of whom there is record who sought alleviation of his bodily ailments by changing climate was of course the sixteenth century Spanish explorer Ponce de Leon. Although he did not find his fabulous fountain of youth in Florida, he did discover a land whose mild subtropical climate has become a haven for the chronically ill.

With the recent increase in life span and the almost complete elimination in this country of all major causes of death except vascular disease, cancer and accident, an increasingly familiar aspect of the American scene has been the annual pilgrimage to Florida of patients with cardiac disease. In view of the usual benefit derived from this pilgrimage, one must conclude that, in one sense at least, these patients have found that fabulous fountain whose absence so disappointed Ponce de Leon.

Although the majority of the vascular victims who seek health in this more temporate clime are patients with arteriosclerotic and hypertensive cardiac disease, those with rheumatic and congenital cardiac disease have come along to Florida looking for help to this more kindly climate.

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 29, 1953.

The patient with rheumatic cardiac disease who comes to Southern Florida comes either to alleviate the distress of his advanced vascular damage or to live in a place where the danger of a potentially damaging flare-up of the active rheumatic state would be minimized. He has ample basis in clinical and experimental observation for his confidence in the ability of the Florida climate to help.

White[1] stated: "Climate appears to be an important factor in the incidence both of rheumatic infection and the rheumatic type of heart disease. In the northern part of the United States the rheumatic infection and its permanent involvement of the heart are five times more frequent than in the southernmost part of the country." Various comparative surveys have shown that the incidence of rheumatic heart disease in Southern California[2] and Arizona[3] is much lower than in colder areas such as Connecticut[3] and Wyoming.[4]

Careful studies by Saslaw, Ross and Dobrin[5] on the incidence of rheumatic fever in native school children in Dade County, Florida, have shown that the incidence there is much lower than in the rest of the country except in Southern Arizona and Redlands, Calif. Further studies by Saslaw, Ross and Hernandez[6] have shown that the incidence of rheumatic heart disease in out-of-state school children in Dade County is much greater than in the native children. This is undoubtedly due to the migration of children with rheumatic cardiac disease to this area.

The low incidence of rheumatic fever and rheumatic heart disease in the native children in Dade County (and I am sure that there is this low incidence also in the remainder of South Florida) is undoubtedly due to the comparatively

low incidence of infections of the upper part of the respiratory tract, especially those associated with the streptococcus. The mildness of the climate allows much more time to be spent out-of-doors than in the Northern climates. This distinction is especially true in the winter months. This leads to less crowding indoors and less spread of those infections of the upper portion of the respiratory tract which do exist. Physicians are all familiar with the way crowding increases the incidence of rheumatic fever, and they know how, all too often, it occurs in too many members of the same family.

Although the studies mentioned have shown that there is no influx of persons with congenital cardiac disease like that of those with rheumatic cardiac disease, there is no doubt that the relative mildness of the climate and the lower incidence of infections of the upper part of the respiratory tract make the lot of those with congenital cardiac disease in Southern Florida a less onerous one. The possibilities of a bacterial endocarditis engrafting itself on a congenitally malformed valve are less in the mild climate. The lessened metabolic requirements of the warmer climate undoubtedly diminish the burden of the congenitally handicapped heart which has difficulty maintaining its compensation.

Although patients with rheumatic and congenital cardiac disease benefit greatly from the mild climate of Southern Florida, it is those with hypertensive and arteriosclerotic cardiac disease who provide the greatest number of vascular victims who seek help there. These sufferers benefit from the climate in many ways. For one thing, they are less susceptible to infections of the upper part of the respiratory tract and to pulmonary infections. These infections, in a more inhospitable environment, too often are the precipitating cause of cardiac failure in a patient who has just been getting by.

In colder environments, there is a constant stimulation to the thermal regulatory centers with consequent metabolic stimulation. Along with this stimulation, there are vascular constriction and increased production of the adrenal steroids with their known deleterious effect on the vascular system.

The angiospasm resulting from cold is, of course, a well known phenomenon. Its effect on the patient with angina pectoris is, too often, markedly to increase the incidence of his anginal episodes to the extent that many such sufferers are forced to spend all of their winters indoors. Such people always benefit greatly from the milder climate in South Florida during the winters.

The patient with peripheral vascular disease also benefits a great deal from the milder climate. It has been strikingly evident to me, as it undoubtedly has been to many physicians here, that although many of my patients have moderately severe to severe impairment of the peripheral circulation, their complaints are surprisingly few. Many of these patients suffered considerably because of the impairment of the peripheral circulation before coming to Florida, and there is no doubt that the lack of stimuli to angiospasm with its accompanying disability is due to the milder weather.

Despite the undoubted benefit derived by patients with arteriosclerotic and hypertensive cardiac disease who flee from the colder weather of the North to the more moderate climate, no study has been made of these patients comparable to the one made of those suffering from rheumatic fever. Surprisingly enough, the one that demonstrates best the effectiveness of warm weather in reducing mortality in heart disease is the work of Brown and Pearson.[7] They analyzed the relationship between mortality due to heart disease and the mean temperatures during the various times of the year in New York City. They used mortality statistics for all types of heart disease for a period of 10 years from 1934 to 1944, and the mortality due to coronary artery disease for five years from 1940 to 1944.

These investigators found that there was an 18.8 per cent increase in the deaths due to heart disease in the colder months, as compared to the warmer months. They were able to show that the average month's temperature deviation from the yearly average varied inversely with the deaths due to all forms of heart disease and also to coronary artery disease (fig. 1).

Although the complaint is often made that it is not the heat, it is the humidity, similar studies on the relationship of deaths due to heart disease and the humidity bore no direct relationship to the variations in death rates, and specifically those due to coronary artery disease.

Even though similar studies are not available for Southern Florida, comparison of the temperatures at the West Palm Beach Weather Station with those in New York shows that the daily temperature maxima, minima and means in New

York City during the months of June, July, August and September were of the same order of magnitude as those reported for the West Palm Beach Weather Station during the months of November, December, January, February. March and April. May and October, although somewhat warmer, are not appreciably so, since the averages are only 3 to 4 degrees higher in those months than at the peak of the New York summer in July when, according to the mortality statistics, the deaths due to heart disease are minimal.

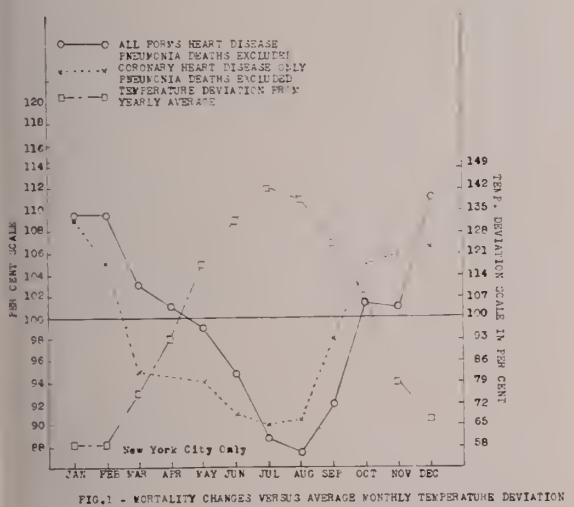


FIG. 1 - MORTALITY CHANGES VERSUS AVERAGE MONTHLY TEMPERATURE DEVIATION

Courtesy, Brown, H. R., Jr., and Pearson, R.: Seasonal Variations in Heart and Coronary Disease as Related to Various Environmental Factors, Am. Heart J. 35:763-768 (May) 1948.

Studies in this area similar to those made in New York are not practical for several obvious reasons. The population varies a great deal between summer and winter, and mortality statistics, using the so-called fixed population as a basis, would be inaccurate. In addition, the large numbers of people with known heart disease who come to this area for mild winters, and who die here despite the beneficence of the climate, would also affect statistics so that results could be neither conclusive nor accurate. It is for these reasons that as yet a similar study has not been attempted. Comparing the cardiovascular death rates in states with more stable populations, however, one finds that the rate in New Hampshire is 644.7 per 100,000, compared to that of New Mexico with 231.3 per 100,000.

A discussion such as this would be incomplete without mentioning some of the work done by Burch[8] on the effect of a subtropical climate on congestive heart failure. His studies were made under conditions of controlled temperature and humidity. His patients with cardiac disease were most comfortable and did best at temperatures from 68.0 to 72 F., averaging 70.3 F., with humidity ranging from 48 to 72, average 60.2. When he subjected these patients to temperatures ranging from 99.0 to 108.3 F., with an average of 104.3 F., they were extremely uncomfortable and, at times, acute congestive failure was induced. In comparing the temperature ranges in his experiments with those reported from the West Palm Beach Weather Station, one finds that the temperatures he reported as optimum for comfort, namely from 68 to 72 F., are of the same order of magnitude as the mean temperatures for the months of November through April, since these were 68 to 74.1 F. The relative humidities reported during these months, taken at 1:30 p.m., are close to those reported by this author as being most comfortable.

The temperatures which proved so deleterious, that is, temperatures ranging from 99 to 106 F. with a mean of 104.3 F., are considerably higher than those experienced in this area, since the average maxima in the hottest months, July and August, never go above 92 and the means never above 83. Since the title of his paper is "The Influence of Environmental Temperature and Relative Humidity on the Rate of Water Loss Through the Skin in Congestive Heart Failure in a Subtropical Climate," in using temperatures between 99 and 108 F. Dr. Burch must have been using his home city of New Orleans as a model. He could not have meant Florida.

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601 South Federal Highway.

Discussion

DR. H. MILTON ROGERS, St. Petersburg: I greatly enjoyed Dr. Davidson's paper. I am a little reluctant to go as far as he has in regard to climate in heart disease because it is difficult to assess the relative merits of climate, infection and even emotional factors in any individual case or series of cases. I particularly recall one patient with myocardial infarction whom I attended in 1940 during his final illness. He had been told in 1920 that if he would go to a certain area in Germany, Bad Nauheim, take the baths and benefit by the climate there, he would not die of heart disease. He made the trip faithfully every year until 1939 and even then, in spite of the fact that he was caught in the war and brought back by ambulance, he was able to make the trip. He died the next year, and his wife still thinks that his death was due to the fact that he did not make the trip to Bad Nauheim in 1940.

In respect to congenital heart disease, every one is familiar with the frequency of bacterial endocarditis. People are less familiar, however, with the syndrome of congenital heart disease and cerebral abscess, which may occur in the absence of bacterial endocarditis, when infection extends directly from the extremities or from the nose or throat to the brain without going through the lungs. The route is directly through a septal defect or through a two-chambered or a three-chambered heart. Then also in congenital heart disease, masquerading as infection are the frequent episodes of heart failure which one sees in children with patent ductus arteriosus, with coarctation of the aorta proximal to the ductus, in cor triloculare and in other anomalies of the heart in which they are considered to have frequent bouts of infection which are in reality bouts of left ventricular failure. So I think this is one factor which makes it difficult to evaluate the role of infection in congenital heart disease.

The subject of rheumatic heart disease will be discussed in more detail by Dr. Saslaw.

I think the most important aid that Florida has to offer the person with heart disease is in arteriosclerotic heart disease and coronary artery disease with angina pectoris. A warmer climate is of definite benefit in persons with recurring angina, but even then the role of emotion, the fact that these patients are away from their business worries, also is important and must be considered along with the climate.

DR. MILTON S. SASLAW, Miami: As Dr. Rogers has mentioned, I will confine my remarks to rheumatic fever and rheumatic heart disease. I think that Dr. Davidson's paper would have created quite a furor had it been given in Boston or New York or Chicago. We here in Florida accept much of what he has said placidly. The fact remains, however, that in rheumatic fever and rheumatic heart disease statistics bear out the benefits that can be obtained, particularly from being born in this area. I might add, too, that recent studies by Graybiel and his group of co-workers in Pensacola have indicated that not only is South Florida of benefit to the patient with rheumatic cardiac disease, but so also are North Florida and West Florida. So from whatever part of the state one may come, he is in one of the best places in the country for the patient with rheumatic cardiac disease.

As to the incidence of infection of the upper part of the respiratory tract and streptococcal infections, I am not quite in accord with Dr. Davidson's remarks. In private practice for a number of years, it seemed to me that there were a great many infections of the upper part of the respiratory tract, and I thought that many of these were probably streptococcal in origin, or if not in origin, at least complicated by the presence of streptococci. And so, a group at the National Children's Cardiac Hospital set out to learn whether streptococci were present or not. We were told by an eminent authority from Boston and New York that there were no streptococci in the Miami area. So this year we have taken throat cultures from presumably normal school children. During the month of February there was an incidence of group A beta hemolytic streptococci in normal school children attending class of a little over 3 per cent of the children studied. In the month of March it rose to 4 1/2 per cent, and for the month of April our figures are not complete, but it appears that there will be an incidence of about 12 per cent of beta hemolytic streptococci in normal school children attending class. One of the next phases in our work will be to determine how many streptoccal infections are actually to be found in the school children, and that will necessitate our going to the homes and getting cultures of those children who are not in school. We believe that although rheumatic fever is benefited in the Miami area and probably in the entire state of Florida, there is some other reason than just the infrequency of infection of the upper part of the respiratory tract and streptococci.

It was a pleasure to hear Dr. Davidson because he has taken up a cudgel that we have been bearing along with a few others in the Miami area for some 10 or 15 years, trying to iron out this problem of climate, especially in contradistinction to the Northern physicians who think that Miami or that Florida is not as ideal a place to live as we paint it.

DR. SIMON D. DOFF, Jacksonville: We are all interested in what Dr. Davidson has to say for geographic reasons as well as clinical reasons, and I think he should be encouraged to pursue his studies on this subject. I should like, however, to utter a word of caution. If death rates in New England states are to be compared with death rates in Florida, we want to remember that the population in the New England states is on the average older than it is in Florida. Similarly, in comparing Vermont with some Southwestern states, we must recognize that the state with a higher percentage of people in the older age groups will have a higher crude death rate for any diseases which are commonest in old people, such as heart disease.

DR. JAMES C. RINAMAN, St. Cloud: It was my privilege to be interested in the original early study of this subject made by Dr. Nichols and Dr. Roche. Of course a considerable amount of work has been done over the last 15 or 20 years. With the fact established that this type of climate is acceptable to patients with cardiac disease, it has been a problem to handle the patients who have been sent or have come to this area ill-advised or not advised by their physicians on how to travel. Many Florida physicians have regretted that these patients have arrived here decompensated to get the salt air and the sunshine, expecting us to get them well. In the early days I can remember many of them who died within a few days. Others were cardiac cripples for many weeks. If there is any way that we can teach the cardiologists and the general practitioners in the North how to advise their patients to travel here to live in happiness forever and ever, we will have done them a great service.

DR. DAVIDSON, concluding: I desire to thank the discussants. Regarding Dr. Rinaman's remarks, I think it was two or three years ago that Dr. Alvin E. Murphy read a paper before a meeting of the Florida Heart Association which was later published in The Journal of the Florida Medical Association (October 1951) on the subject of the indignities that we cardiologists in the state suffer at the hands of our Northern colleagues who have a tendency to dump their patients with cardiac disease in this area without proper precaution and also without proper advice.

Climate in relation to heart disease is an extremely difficult subject on which to carry out careful accurate statistical work, especially in relationship to patients with arteriosclerotic and hypertensive cardiac disease. As far as those with rheumatic cardiac disease are concerned, that work is being done and done well at this time by Dr. Saslaw at the National Children's Cardiac Hospital. I find it extremely difficult, however, to get accurate statistics and good careful experimental work which would show what all of us have observed clinically for many years, that this climate is a good climate for the patient with arteriosclerotic hypertensive cardiac disease. I believe that there should be more investigation, if possible, to show exactly why this climate is better, if it is.

The Surgical Treatment of Cancer of the Cervix and Uterine Fundus

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In considering the surgical treatment of cancer of the cervix and of the uterine fundus, some details will be discussed of the methods used in establishing the diagnosis and its site, although the greatest emphasis will be, of course, on the treatment and results after the diagnosis has been confirmed.

We are fortunate in Rochester, Minn., in having a great number of patients pass through our clinic and we are able, therefore, to reach conclusions in a relatively short time that would be otherwise impossible. In 1951, for instance, there were 557 patients with malignant lesions of the female genitalia. Some 12 of these lesions were metastatic from the breast, stomach or other organs, and many patients were sent home as having inoperable lesions without exploration or extensive tests to determine the site of the original lesions. There were in 1951, however, 149 invasive squamous cell epitheliomas and in addition 70 were carcinoma-in-situ, or stage 0, 20 adenocarcinomas of the cervix and endocervix and 40 not specified. There were 126 malignant lesions of the uterine fundus. The remainder of the tumors were carcinoma of the vagina 10, vulva 18, fallopian tube 1, ovary 95, and miscellaneous group of 10 cases of multiple or widespread malignant lesions in which the primary site was not verified.

Carcinoma-in-situ of the Uterine Cervix

Cervical carcinomas-in-situ, or League of Nations stage 0, form a group in which the treatment and the prognosis are so entirely different from treatment and prognosis of the other cervical tumors that they need to be considered separately. They are found in younger women, the average age being 35 to 40 years compared to 48 years for invasive cervical carcinoma. There are no characteristic symptoms. There may be a history of vaginal spotting following trauma or a mild leukorrhea but this, of course, occurs in many benign conditions and is not by any stretch of the imagination characteristic of carcinoma-in-situ. The cervix may or may not show sufficient areas of erosion to arouse the interest of a suspicious observer and even when the erosion is extensive, it is not pathognomonic of early carcinoma. These lesions, therefore, must be diagnosed through routine biopsies of all areas of erosions or leukoplakia. In addition, great help is available through the screening process of vaginal smears, thus enabling the physician to pick out of the symptomless group those patients in whom further investigation is indicated.

During the past year our pathologists received material from approximately 10,000 patients seen in the Section of Obstetrics and Gynecology and out of this group they reported some 100 suspiciously positive or positive smears for malignant cells. The patients were then advised to have office biopsies or biopsies under anesthesia, and the diagnosis of malignant disease was confirmed in all but 1 or 2 cases. The pathologist, when studying the office biopsies, is of necessity studying small bits of tissue and therefore is reluctant to state definitely that the lesion is in-situ in all areas. The report of the vaginal smear when positive is, therefore, returned as "carcinoma of the cervix, apparently in-situ." This report to the clinician conveys the information that in none of the available blocks of tissue was invasive carcinoma found, but intimates that the pathologist would appreciate receiving further and larger specimens.

Surgical consultations are then requested, and the patient is sent to a hospital for biopsy under anesthesia and treatment as thereby indicated. The surgical specimens for biopsy are large and are practically a conization of the central cervical

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and endocervical areas in order to get the important squamocolumnar junction. Frozen sections are immediately made, studied and reported as either carcinoma-in-situ, invasive carcinoma, or no residual carcinoma found. Not infrequently even small office biopsies when accompanied by light cautery to control bleeding result in enough destruction of the surface layers of the cervix so that the pathologist finds no identifiable carcinoma. When carcinoma-in-situ has been diagnosed on the basis of the office biopsy with no residual at operation, or when only carcinoma-in-situ is found in the surgical biopsies, our treatment has been hysterectomy including a 1 to 2 cm. vaginal cuff. My colleagues and I perform either a vaginal or an abdominal hysterectomy with preservation of the ovaries. Our belief concerning vaginal hysterectomy is that if the uterus can be removed without undue trauma to the cervix, without having to shift the position of the tenacula on the cervix, and without the necessity of hemisection or morcellation, then vaginal hysterectomy is a most satisfactory procedure. When, because of minimal descensus, or minimal vaginal relaxation, or the size of the uterus, we employ abdominal hysterectomy, we endeavor to remove at least a moderate cuff of vagina. If frozen sections reveal the carcinoma-in-situ extending out onto the vaginal mucosa, we immediately resect a further large cuff of vagina; however, this happens rarely.

We do not have sufficient long term follow-ups on these patients to offer any statistical evaluation of their prognosis. The carcinomas-in-situ comprised roughly 1 per cent of cervical malignant lesions before 1948 and now are about one third of all the cervical malignant lesions. In 1952 there were more than 80 cases of carcinoma-in-situ at the clinic, but most of our material has not yet approached a five year follow-up. There has been only 1 case in which we have suspected a recurrence. The patient had a positive vaginal smear one year after abdominal hysterectomy for carcinoma-in-situ. Biopsies revealed a carcinoma-in-situ of the vaginal vault. The vaginal vault was resected going widely around the area of carcinoma-in-situ, and the patient has been well and shows no signs of recurrence since the last operation. In serial sections, however, of the previously removed cervix we were able to find a tongue of carcinoma extending from the cervix out onto the vaginal wall to the edge of the surgical specimen. This patient, therefore, did not have a recurrence but only an incomplete removal of her original carcinoma. There is no agreement as to what might constitute adequate and good care of the patient with carcinoma-in-situ of the cervix. Te Linde[1] at Johns Hopkins advocated a radical hysterectomy removing the adjacent adnexal areas and a sizable cuff of vaginal mucosa but frequently leaving one ovary. The pelvic lymph nodes are not removed.

Scheffey and Lang[2] at Jefferson Medical College follow the other extreme; they believe that careful observation of in-situ lesions with circular biopsies and Papanicolaou smears at intervals are sufficient to control these patients.

One controversial point remains to be touched upon, namely carcinoma-in-situ during pregnancy. Considerable discussion has arisen on this subject which boils down to one fact. Either the pathologist can distinguish carcinoma-in-situ from epithelial changes in the cervix or he cannot. We are fortunate in having, associated with our surgical division, pathologists who believe they can diagnose the changes of pregnancies and can accurately identify the unusual carcinoma-in-situ seen during pregnancy. Our preference then is hysterectomy, though we have procrastinated in several cases after thorough discussion with the patient and her family of the diagnosis, of our usual treatment and of the element of risk involved.

Invasive Carcinoma of the Cervix

When invasive carcinoma of the cervix is diagnosed, our treatment at the Mayo Clinic has changed during the past few years. Until 1949 we treated stage I and many stage II lesions by Wertheim hysterectomy without preoperative radiation. By Wertheim hysterectomy is meant a radical hysterectomy, with bilateral salpingo-oophorectomy, removal of one third to one half of the vagina, and a bilateral dissection of the iliac, hypogastric and obturator nodes. The remaining patients all received radiation, both radium to the cervix by intensive broken dose technic and deep roentgen therapy to the lower part of the abdomen through two anterior and two posterior portals. Only a few of these patients, because of radioresistant lesions or the development of pyometra or ovarian cysts, or other factors, were later seen by the surgeons. The results obtained in the non-irradiated selected surgical patients were good, but in an effort to better our over-all survivals we have now changed and endeavored to treat all invasive carcinomas of the cervix with pre-

operative radiation, approaching 7,000 mc. hours to the cervix in broken dosages and 1,000 to 1,500 air units of roentgens through each of four portals to the sides of the pelvis. The patients are seen three months later by gynecologist, surgeon and radiologist, and when one is a suitable candidate for surgical treatment, a Wertheim hysterectomy is advised. Owing to increased general interest in the cervical malignant lesions, we are now performing almost five times the number of Wertheim hysterectomies per year that were performed 10 years ago.

The ratio of cases in which resection was performed to total cases diagnosed has therefore increased from 10 or 15 per cent operability rate to a better than 33 per cent rate, and if carcinoma-in-situ were included, the rate would be well over 50 per cent. Our operability rate for invasive carcinoma of better than 33 per cent compares with Schlink's[3] of 50 per cent, Bonney's[4] of 63 per cent in ward patients and 80 per cent in private patients, and Morton's[5] of 10 per cent.

In almost all of the surgical patients before 1949 the lesions were originally considered stage I or stage II, although a few are stage III or IV. The staging of lesions is on the basis of the League of Nations classification (table 1).

Table 1.—Wertheim Hysterectomy 1930-1952: Distribution According to Stage

Stage	Number	Per Cent
I	162	55.3
II	108	36.8
III	21	7.2
IV	2	0.7
Total	293	100.0

In the last three years there has been a decided swing to the stage II and stage III lesions following radiation so that now in the majority of the patients undergoing Wertheim hysterectomy the lesions are stage II or stage III. It is necessary, therefore, to have series large enough not to compare surgical treatment with and without preoperative radiation but to compare lesions of similar staging with various forms of treatment.

The estimation of the stage is clinical and is made on the first visit of the patient before any treatment is undertaken. This original staging is utilized in all future studies, since this is the only one that can be satisfactorily used in the comparison of series of cases. All later groupings and staging, such as the surgical and pathologic data, are influenced by the previous treatment, though they are most helpful in the prognosis to the family. By definition we say a stage I malignant lesion is confined to the cervix, but probably 10 to 15 per cent of the clinical stage I malignant lesions will be found at operation to have positive nodes and some with such widespread involvement of aortic nodes as to be technically inoperable; surgically such a lesion is a stage IV lesion, but clinically it is a stage I lesion modified by the finding of positive nodes.

The patients are selected for surgical treatment on the basis first that the lesion seems technically removable and secondly that the patient presents a fair surgical risk. The results of radiation alone are too good to warrant advising patients to undergo an excessive surgical risk. The patient with severe cardiac or renal disease is excluded, and those with general debility are poor candidates for radical surgical treatment, as are the elderly. A physiologic age of more than 60 years is a fair criterion of increase in surgical risk, though certainly it is no absolute contraindication to surgical treatment. The obese patient, especially the patient with a round, protuberant, firm abdomen, makes an operation extremely difficult and tedious, and she does not tolerate prolonged surgical manipulation or anesthesia well. It is, therefore, wise on the initial visit to warn overweight patients that surgical treatment may be contemplated later and that it behooves them to get in the best possible shape for it by losing what excess weight they can. It has been an interesting observation during the last three years when almost all of the patients have had preoperative radiation that it is often easier to perform a pelvic node dissection on the moderately obese patient with a soft relaxed abdominal wall than on the thin patient whose pelvis has received full benefit of intensive radiation therapy. Since the fat of the heavier patient has filtered out much of the radiation, there are fewer changes due to radiation on the sides of the pelvis along the external and internal iliac vessels and the node-bearing fat can be stripped rather quickly and easily.

Our estimation of a technically removable lesion is based on the original staging and on the

pelvic examination as well as on roentgenograms of the patients three months after the preoperative radiation. Distant metastatic growths and the development of pain with a sciatic distribution and increasing in severity would exclude surgical treatment. Edema of one or both legs is highly suggestive of an inoperable lesion. Fixation of the pelvic structures to the lateral pelvic wall or direct invasion of bladder or rectum precludes the usual Wertheim hysterectomy. Such a patient, however, is at times amenable to some form of eventration operation. A radioresistant lesion, as suggested by smears or proved by biopsy, of course, strongly influences the choice of surgical intervention since the patient's prognosis is otherwise almost hopeless, though further radiation may give some palliation.

The details of technical procedures followed in carrying out a Wertheim type hysterectomy for invasive carcinoma of the cervix would not be of interest to this meeting. Suffice it to say that it is a prolonged operation with considerable loss of blood, and it requires the surgeon to work along and around the large vessels, nerves and organs of the pelvis, removing the generative organs and the regional lymphatic nodes and channels. This must be done; yet irreversible damage to the surrounding structures must be avoided. Nor can the surgeon forget that bladder, ureters, bowel or blood vessels may be involved directly by an otherwise operable lesion and he must be ready to take such steps as are necessary to go around the growth. Fortunately, most of the pelvic viscera are tolerant of damage if it is repaired promptly and the viscera are otherwise treated with gentleness and courtesy. If the training of the surgeon does not permit his performing a satisfactory, complete operation, handling difficulties as they arise, then in all probability more patients will survive with good radiation therapy than with incomplete surgical treatment.

The results, the difficulties and the early and late sequelae of such operation are pertinent in this discussion. The difficulties include hemorrhage, finding invasion of bladder, rectum, ureters, and other structures, or the damage of any of these viscera or the fixation of nodes to blood vessels by inflammations or tumor. Although the fascial planes tend to prevent early direct invasion of bladder or rectum, these are possibilities, and in such cases there is nothing to do but try to get around the tumor and repair the damage carefully when the operation is finished. Ureters can be cut and, if so, the most satisfactory course is reimplantation of the ureter into the bladder, which fortunately is not difficult. Blood and fluids keep surgical shock at a minimum as the low operative mortality rate in all recent large series of cases indicates.

Postoperatively we see surprisingly little to no bleeding and this in spite of the fact that many small vessels are controlled by pressure during the operation and by prayer afterward. Even hematomas are infrequent. The bladder gives the greatest difficulty, and we leave an indwelling catheter for five days, then recheck the residual urine twice daily. The catheter is left in the bladder for 24 hours if residuals persist at 400 to 500 cc. When trouble continues after 10 days, we try three to four bottles of strong beer per day. The patients love it, feel more relaxed and have fewer worries, while the fluid content keeps the urine output up. Seldom do we have a patient in the hospital longer than 14 days because of the bladder refusing to empty, and only 3 patients have remained for as long as three weeks.

Table 2.—Morbidity Following Wertheim Hysterectomy 1930-1952

Interval, Years	Patients	Morbidity*		Postoperative Deaths	
		Number	Per Cent	Number	Per Cent
1930-1934	31	29	93.5	4	12.9
1935-1939	27	21	77.8	1	3.7
1940-1944	46	28	60.9	4	8.7
1945-1949	70	35	50.0	0	0
1950	29	15	51.7	0	0
1951	40	21	52.5	0	0
1952	50	20	40.0	0	0
Total	293	169	57.7	9	3.1†

*Occurrence of temperature of 100.4 F. or higher on any two or more days following the day of operation.
†Last death, 1943; 205 consecutive Wertheim hysterectomies without a postoperative death since then.

Infection is still a factor to be reckoned with though not to the extent it was 15 years ago. In this group of patients there have been 16 major pelvic infections or abscesses; 5 occurred before the era of chemotherapy with 2 deaths in these 5 patients. In a number of other patients there developed vaginal discharges from serous to frankly purulent; yet these patients showed little elevation of temperature or subjective symptoms as the accompanying morbidity chart (table 2)

illustrates. Many minor aches and pains follow this operation, most of which are undiagnosed, but the average stay in the hospital is less than two weeks, and the patients soon forget or minimize their postoperative difficulties.

Table 2 well illustrates the effect of chemotherapy on this particular operation and the decided decrease in morbidity and mortality that has occurred since the use of the antibiotics. The basis for determining the morbidity is a strict one; yet morbidity reached a low of 40 per cent in 1952 and this in spite of the fact that 43 of 50 patients underwent preoperative radiation.

Phlebitis is a hazard but not more so than in other surgical procedures; there were 2 proved and 1 suspected fatal pulmonary emboli. Dicumarol was not used prophylactically in the majority of these patients though it is employed immediately if there is any suggestion of thrombosis. Thrombophlebitis may occur three to four weeks after the patient has been dismissed, and we have had at least 3 such occurrences.

Fistula is the late sequela that has helped give this operation a poor reputation. In 293 patients we had 13 fistulas, an incidence of 4.4 per cent. There were 3 ureterovaginal fistulas. Nephrectomy was performed in 2 cases and a reimplantation of the ureter in 1 case. One patient who had a rectovaginal fistula died in six months, and 1 patient who had a rectovesicovaginal fistula died in 18 months, both of extensive metastatic growths. There were 8 cases of vesicovaginal fistula: 1 patient died of a recurrent malignant lesion, 4 fistulas healed spontaneously, and 3 were repaired. We have not had many late ureteral obstructions, but in 1950-1952 there were 4 such cases. In 1 case the obstruction was due to metastasis, and the patient rapidly died. One ureter was reimplanted in the bladder, the third patient underwent nephrectomy, and the fourth underwent a transurethral dilatation.

So much for the postoperative difficulties and sequelae. What after this work have we accomplished for these women? We do have five year follow-up studies on the patients from 1930 through 1945.[6] There were only a scattering who had any preoperative radiation, but of the 109 patients surviving the operation and whom we could trace, 87 (79.8 per cent) were alive and well five years later (table 3).

In the four "lost" patients the lesions were stage I without nodes and would probably increase the five year survival rate if found. The five year evaluation in this surgical group of non-irradiated cases is an excellent criterion for we found that only 2 patients died in the fifth year and 1 in the sixth year. There are also 2 patients who underwent operation in 1946, 1 of whom died early in 1953 and the second, who has had known perineal metastatic growths for two to three years, now has a colostomy, but shows no further evidence of trouble following radiation therapy to the perineum.

Table 3.—Survival Rates After Wertheim Hysterectomy for Squamous Cell Epithelioma of the Cervix*

Period, Years	Patients		Lived Beyond Indicated Period	
	Total	Traced	Number	Per Cent†
3	135	130	112	86.2
5	113	109	87	79.8
10	56	55	36	65.5

*Inquiry as of Jan. 1, 1951. Included in the three year group are only those patients who were operated on three or more years prior to the time of inquiry, that is, in 1947 or earlier; the five year group includes those patients operated on in 1945 or earlier; the 10 year group includes patients operated on in 1940 or earlier.
†Per cent of traced patients.

Table 4.—Five Year Survival Rates After Wertheim Hysterectomy According to Stage*

Stage	Patients		Lived 5 or more years after operation	
	Total	Traced	Number	Per Cent†
I	76	72	61	84.7
II	29	29	24	82.8
III	7	7	2	28.6
IV	1	1	0	0
Total	113	109	87	79.8

*Inquiry as of Jan. 1, 1951. Included are only those patients who underwent operation five or more years prior to the inquiry; that is, in 1945 or earlier. Hospital mortality is excluded in the calculation of the survival rates.
†Per cent of traced patients.

Table 4 shows the five year survivals according to the clinical stage of the disease. There were 7 stage I cases and 7 stage II cases with involved nodes included in this study. Even though the number of stage II cases is small, the five year survivals are a remarkable 82.8 per cent. In stage I lesions without positive nodes the five year survivals were between 89 and 90 per cent. Since 1949 the majority of patients have undergone preoperative radiation, and the number of

operations per year has more than doubled so that before long we will have, from our own records, series of patients with and without preoperative radiation to try to estimate the effect of the radiation on the five year survivals.

The effectiveness of radiation on the pelvic nodes has been a highly controversial point. Henriksen,[7] in a study of 420 patients who died of cancer of the cervix, found that fibrosis plus hyalinization was present in the lymph nodes of 88 per cent of the patients treated by irradiation, but it was also present in 12 per cent of the patients who had had no irradiation. Morton[5] reported 35 per cent involved pelvic nodes in 51 nonirradiated patients and only 11 per cent in 43 postirradiated ones. Schlink[3] of Australia, however, has expressed the belief that irradiation has no effect on the pelvic nodes and therefore preoperatively he used only radium to the cervix.

In reviewing our 293 patients, we had 171 with no preoperative radiation and 122 who had undergone irradiation before their surgical treatment. In the stage I malignant lesions there were 119 without preoperative radiation; 10 of these (8.4 per cent) had metastatically involved lymph nodes. Of 43 stage I lesions with preoperative radiation, 5 (11.6 per cent) had metastasis to the nodes. In stage II lesions, 10 (24.4 per cent) of 41 without preoperative radiation had metastasis, and 16 (23.9 per cent) of 67 with preoperative radiation had metastasis. There were only 11 stage III lesions which had not been irradiated, and 4 had positive nodes; following irradiation 2 of 10 showed positive nodes. These series of cases graded and treated by the same group of physicians are now becoming large enough to be of statistical interest and would certainly seem to question the effectiveness of irradiation on pelvic lymph nodes with metastatic cancer.

Malignancy of the Uterine Fundus

Carcinoma of the uterine fundus falls between invasive carcinoma of the cervix and carcinoma-in-situ in its prognosis and varies from both of these two latter lesions in the type of tumor that is usually encountered. The malignant lesions of the fundus are not as common as those of the cervix; between 1910 and 1944 there were 3,799 carcinomas of the cervix and 1,578 carcinomas of the uterine fundus seen at the Mayo Clinic, a ratio of about 2.5:1. The lesions of the fundus are predominantly adenocarcinoma, 80 to 85 per cent, the remainder being squamous cell carcinoma 5 to 6 per cent, adenoacanthoma 5 to 10 per cent, and a rare mixed group of sarcoma and so forth, 1 to 3 per cent. The adenocarcinomas which arise from the endometrial glands are largely of grade 1 or grade 2 malignancy and only 15 to 20 per cent are high grade 3 or grade 4 tumors.

The patients with a fundal malignant lesion are older than those with cervical lesions, the average age being about 58 years, or roughly 10 years beyond the average age of the menopause. Also many of these patients had a delayed menopause and continued menstruating after they were 50 years old.

Vaginal bleeding is, of course, the outstanding complaint of these women, though any change in color or odor of the vaginal drainage is significant and the older the patient the more significant it becomes. In the postmenopausal woman bleeding means malignant disease in 20 per cent or more of the patients, and a daily spotting or staining is the more characteristic finding.

The diagnosis must be made on the basis of endometrial biopsies, preferably dilatation and curettage under anesthesia. If the surgeon is fortunate, a competent pathologist will be present who can make and accurately interpret frozen sections. In such a case the diagnosis is established in a period of minutes and the type of treatment best suited to the patient is begun. In Rochester we believe that immediate total abdominal hysterectomy with bilateral salpingo-oophorectomy is the procedure of choice. We pack the uterus when the diagnosis is confirmed, then suture the cervix, reprepare the vagina by thorough scrubbing with liberal quantities of soap and water and open the abdomen through the lower midline. Our first thought is the question of tubal, ovarian or peritoneal implants in the pelvis, then palpation of the liver and upper part of the abdomen for distant metastatic growths. When the uterus, tubes and ovaries have been removed, we investigate the node-bearing areas on the sides of the pelvis and remove any grossly enlarged nodes that may be present. In 1950-1951, 1 patient with positive nodes was found in 5 in whom enlarged nodes were removed. It is particularly important in the rarer high grade malignant lesion to remember that lesions may spread to the lateral pelvic nodes early.

In a few of the patients with adequate relaxation and with low grade carcinomas, a vaginal hysterectomy is performed instead of an abdominal one. The latter is preferable, but in some elderly

patients, or excessively obese patients, or those in whom the cardiac status increases the risk of abdominal surgical procedures, a vaginal hysterectomy is the procedure of choice, and the prognosis is good. From 1930 through 1946, 82.7 per cent of these patients survived five years following vaginal hysterectomy for carcinoma of the uterine fundus.

When increasing risk due to age, obesity or concomitant disease outweighs the advantages of surgical treatment, then radiation still has a great deal to offer. Later a few through loss of weight, change in cardiac status, and other factors, are found to be satisfactory for a surgical procedure, and if so the removal of the uterus is then advised.

One group deserves special attention. When a malignant lesion of the fundus occurs in a patient aged less than 40 years,[8] the patient often falls into a predictable pattern of the four "h's," or heavy, hairy, hypertensive and h'infertile. The girls tend to be irregular in amount of flow of the menses, as well as in rhythm, and there are often associated months of amenorrhea. Fertility is low, and conception is infrequent. The ovaries may be symmetrically enlarged. At operation the ovaries often are two to three times normal size with thick, hard rinds and numbers of unruptured follicular cysts, the typical ovary of the Stein-Leventhal syndrome. Most of the fundal malignant lesions seen in patients aged less than 40 are grade 1; therefore the prognosis is unusually good, and the five year survivals are numerous.

In any discussion of carcinoma of the uterine fundus the question of preoperative radiation is always pertinent. We have not used radiation as a primary form of treatment but only in those cases in which, because of obesity or concomitant disease, the patients were considered to be poor surgical risks yet later may become good risks. Our primary mode of treatment is hysterectomy without preoperative radiation. Radiation is certainly not the whole answer since 30 per cent or more of the postradiation uteri will exhibit residual malignant tissue following their radiation. Corscaden,[9] in a scholarly review, came to the conclusion that hysterectomy alone should give at least a 60 per cent five year survival and perhaps 70 per cent. A few physicians can approach this with planned radiation therapy. He presented evidence of the effect of radiation on metastatic growths and concluded that the combination of radiation and hysterectomy gives better results than either alone.

During the 17 year period from 1930 through 1946 at the Mayo Clinic we saw more than 1,000 patients whose disease we diagnosed as adenocarcinoma of the uterine fundus.* Of the 729 surgical patients, we have been able to trace 667 or 91.5 per cent, and of these 295 were treated by hysterectomy and radiation therapy, and 372 were treated by hysterectomy alone. Our over-all five year survivals of those treated by hysterectomy with or without postoperative radiation was 75.0 per cent. Abdominal hysterectomy without radiation gave a five year survival rate of 81.5 per cent, and hysterectomy plus postoperative radiation a five year survival rate of 64.8 per cent. The lowered survival rate with radiation was, of course, due to the utilization of postoperative radiation when there were questionable metastatic growths, deep penetration of the uterine wall and the like. Although a few of these patients had undergone dilatation and curettage elsewhere and were then referred to us so that their hysterectomies were performed a few days to a week or two after the initial surgical procedure, in the great majority the diagnosis was made by frozen sections, and surgical intervention was immediately carried out.

There were also 81 patients who had undergone vaginal hysterectomy in these 17 years who could be traced; 67 (82.7 per cent) survived five years.

The hospital mortality rate was higher than we would like; there were 14 deaths among 651 patients with abdominal hysterectomy or 2.2 per cent mortality. Most of these deaths occurred in the early 1930's, and there was only 1 death in 1940 and a final 1 in 1946. Among the total of 93 patients subjected to vaginal hysterectomies there was only 1 death and this occurred in 1932.

Summary

A brief discussion is presented of the results of the surgical treatment of carcinoma-in-situ of the cervix, of invasive squamous cell epithelioma of the cervix and of adenocarcinoma of the uterine fundus.

The lack of diagnostic symptoms or findings is emphasized in the carcinomas-in-situ and the necessity of the use of routine biopsies in all suspicious cervices or in any with cervical erosion. The examination of vaginal smears as a screening process of numbers of patients is useful. Varia-

*Study being conducted at the present time.

tions in treatment are mentioned, and abdominal or vaginal hysterectomy is advised as having been satisfactory in our hands.

The surgical treatment of invasive squamous cell epithelioma of the cervix with a follow-up of 109 cases from 1930 through 1945 inclusive is reviewed. In this group treated with surgery and without preoperative radiation, the over-all five year survival of traced patients was 79.8 per cent, while in stage I lesions it was 84.7 per cent, and in stage II lesions a surprising 82.8 per cent. The attending difficulties and complications of the Wertheim hysterectomy are emphasized. Finally, the policy at the clinic in the last four years to use preoperative radiation wherever feasible will soon furnish a series of patients who can be compared to the surgical patients without preoperative radiation both as to complications and as to five year survivals.

Adenocarcinoma of the uterine fundus is seen primarily in an older group of patients and can be suspected on the basis of postmenopausal bleeding. The controversial point of the use of preoperative radiation is discussed briefly. Dilatation and curettage with diagnosis by frozen section and immediate hysterectomy are at present the practice at the Mayo Clinic, and the results from 1930 through 1946 show that 75.0 per cent of those treated by hysterectomy with or without radiation survived five or more years.

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Mayo Clinic.

High Creatinemia with Recovery in a Patient with a Congenital (Single) Kidney

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It is now 30 years since it was first observed that the creatinine in the blood is greatly elevated in cases of severe renal impairment. Folin was the first to show that the amount of creatinine excreted in the urine by a normal person on a meat-free diet is quite independent of either the amount of protein in the food or the total nitrogen in the urine, the amount excreted from day to day being practically constant, thus pointing conclusively to its endogenous origin. Recently it has been proved by the use of tracer isotopes that creatinine originates from creatine. This is formed from glycine and arginine in the kidney while glycocyamine is methylated in the liver by methionine to form creatine.

High values for blood creatinine (over 4 mg. per hundred cubic centimeters) have been observed in a variety of conditions causing clinical azotemia and these fall into three main categories:

(1) Primary renal azotemia includes various forms of Bright's disease, but chiefly glomerulonephritis and nephrosclerosis, pyelonephritis and bilateral polycystic kidney disease.

(2) Extrarenal azotemia includes such varied conditions as anuria caused by chemical poisoning (bichloride of mercury and phenol), incompatible blood transfusions, pregnancy toxemias, severe burns; crush, blast and submersion syndromes (the shock kidney), and anuria occurring as a reflex following instrumentation. It is in this group of cases of renal failure, in which there

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Read before the staff of the Edgewater Hospital, Miami, March 18, 1953.

is hope that the kidneys may regain adequate function within a fairly short time, that the use of the artificial kidney is indicated.

(3) Postrenal azotemia, or obstructive uropathy, includes anuria caused by calculus blockade, prostatic hyperplasia and hypertrophy, vesical neoplasms, contractures of the vesical neck, and mechanical obstruction or surgical injury to any part of the urinary tract (accidental severance or ligation of the ureters).



Fig. 1. — Retrograde pyelogram with blood clot at ureteropelvic junction.

Attention was first called to the unfavorable prognostic import of an elevated blood creatinine by Myers and Lough[1] in 1915. They suggested that since creatinine was almost wholly endogenous in origin and furthermore since it was apparently the most readily eliminated of the three nitrogenous waste products, uric acid, urea and creatinine, it should be of greater prognostic value than either uric acid or urea. These authors stated in their original paper: "The creatinine rises above 2.5 mgs. per 100 cc. of blood almost without exception only in conditions with renal involvement. Creatinine values from 2.5 to 3.0 mgs. may be viewed with suspicion; figures from 3.0 to 5.0 mgs. regarded as decidedly unfavorable, while over 5.0 mgs. probably indicates an early fatal termination." It soon became apparent, after studying reports of many observers of survival cases, that while elevations of over 5.0 mg. of creatinine usually indicated a fatal prognosis in the primary renal azotemia, this was not true in the acute conditions comprising the extrarenal and postrenal azotemias.

Gaberman and others[2] studied 44 cases of azotemia in the three categories mentioned. No diagnostically significant correlation between creatinine and nonprotein nitrogen was found in any of the three groups. Although the creatinine level may be increased in proportion to the nonprotein nitrogen elevation in all three categories, a creatinine value disproportionately low as compared to the elevation of the nonprotein nitrogen is usually indicative of extrarenal or postrenal azotemia. Instances can occur, however, in which an extrarenal or postrenal condition may be superimposed on a kidney with parenchymatous disease. The following case report might well illustrate such a combination:

Report of Case

L. K., a man aged 63, was admitted to the Edgewater Hospital on August 14, 1952, with a history of failure to pass urine for seven days. He had been treated by a local physician with mercuhydrin administered every four hours, and when this therapy failed, called another physician who promptly hospitalized him. The patient stated that he had passed a calculus three years previously and was of the opinion that he may have passed another stone two days before the onset of his present illness. On admission, the blood nonprotein nitrogen was 158 mg. per hundred cubic centimeters and the creatinine 14.5 mg. These determinations were repeated with the same results. The blood count at the time of admission was white blood cells 11,700; polymorphonuclears 81 per cent, small lymphocytes 13 per cent, monocytes 2 per cent, eosinophils 4 per cent; red blood cells 3,860,000; hemoglobin 74.1 per cent, or 12.6 Gm.; color index less than 1.



Fig. 2. — Excretion pyelogram. Blood clot no longer visible.

On cystoscopy the right ureteral orifice was the site of pronounced bullous edema and gave the appearance of a calculus trapped in the intramural portion, or one that recently had been expelled. No ureteral orifice was visible on the left side. Indigocarmine injected intravenously failed to appear after an interval of 20 minutes. A French No. 6 catheter was passed up the right ureter for a distance of 27 cm., without encountering obstruction. Almost 600 cc. of urine under tension was released. A roentgenogram failed to reveal a kidney shadow on the left and gave no evidence of opaque calculi on the right. A small nonopaque shadow within the pelvis was thought to be a blood clot. Reasoning that we were dealing with a large extrarenal hydronephrosis, secondary to a blockade at the ureteropelvic junction, we decided to dispense

with the retrograde pyelogram. In view of the operative findings, however, this procedure would have been helpful. We felt justified in advising exploration of the kidney for the following reasons:

(1) Removing the retained urine would not necessarily relieve the pathologic condition causing the blockade;

(2) Indwelling catheter drainage in our experience has been unsatisfactory since the catheters are usually expelled in 2 or 3 days;

(3) It was hoped that in the face of a postrenal azotemia, nephrostomy tube drainage would restore kidney function more quickly.



Fig. 3. — Aortogram showing absence of renal circulation on the left side.

At operation the kidney was tense and twice its normal size. The ureter, which was normal, was traced upwards to its entrance into an intrarenal pelvis. The tip of the catheter, which was left indwelling at cystoscopy, was now felt just below the ureteropelvic junction. It had apparently slipped out of the pelvis when the patient was placed in position on the table. The ureter was opened between two guide sutures just below the ureteropelvic junction, and a firm organized blood clot, adherent to the ureteral wall, was removed. A French No. 32 Malecot nephrostomy tube was now introduced into the renal pelvis, and a French No. 11 Levin tube, to serve as a splinting catheter, was passed well down the ureter. Both tubes were brought to the outside through a stab wound in the loin. The outer coats of the ureteral wall were approximated with a single catgut suture, the kidney replaced, and the wound closed in layers.

On the second postoperative day the blood nonprotein nitrogen totaled 110 mg.; the creatinine was 4.35 mg. The following day the patient passed 20 cc. of grossly clear urine which apparently had seeped into the bladder alongside the splinting catheter. Examination of a large blood clot expelled immediately afterward failed to reveal the presence of a calculus. On the fourth postoperative day the blood nonprotein nitrogen was 40.4 mg. and the creatinine 2.6 mg. On the next day excretion urography failed to reveal any evidence of dye in the left renal fossa to indicate the presence of a kidney on that side. The presence of dye in the bladder was confirmatory evidence that urine from the right renal pelvis was escaping alongside the splint even though the nephrostomy tube was draining well. Intake for 24 hours totaled 3,000 cc., and the output was 2,000 cc. By the eighth postoperative day the temperature was normal, the blood nonprotein nitrogen was 39.5 mg. and the creatinine 2.1 mg. The splint catheter was removed on the thirteenth postoperative day. Four days later the patient began to void in small amounts every two hours. He was discharged from the hospital on the eighteenth postoperative day with the nephrostomy tube draining well, and the operative wound healed by primary union.

The nephrostomy tube was removed on the thirty-ninth postoperative day.

Approximately one month after his discharge from the Edgewater Hospital, the patient entered Mercy Hospital because of a draining lumbar sinus and for further study. On cystoscopy a ureteropyelogram was obtained with the use of a bulb occlusion catheter. Following this procedure a French No. 9 catheter was left indwelling. Two days later excretion urography was performed. The blood clot present on the retrograde pyelogram was no longer present. Because of a suspicious filling defect in the lower calyx, cytology studies were made. They demonstrated atypical cells, grade II. This finding was not regarded as significant. On the following day angiography was performed, with the use of 70 per cent Urokon sodium; this demonstrated the absence of renal circulation on the left side, confirming the diagnosis of renal agenesis. The operative sinus was dry. The indwelling catheter was removed after three days, and the patient was discharged.

When last seen on October 17, he was asymptomatic.

Conclusion

A case of pronounced creatinemia in a patient with a single congenital kidney is presented.

Creatinine values of over 5 mg. in the blood are not necessarily fatal if the azotemias are of the extrarenal or postrenal varieties.

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The Basic Principles of Medical Renal Disease

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A discussion of the basic principles of medical renal disease will be presented in an attempt to relate the anatomic and biochemical pathologic changes with the clinical manifestations, and to derive therefrom a practical therapeutic approach. Such a discussion should logically commence with the physical elements which are involved in these pathologic changes, the nephron, its vascular supply and immediate environment, and the interstitial tissues.

The Glomerulus

This is a tuft of capillaries connected by a loose areolar tissue and enveloped by a simple epithelial layer of cells, which is the invaginated portion of Bowman's capsule. Between the endothelial layer of cells of the capillary wall and the epithelial cells is an homogenous basement membrane.

The glomerular tufts differ from the capillaries elsewhere in the body in the following respects: (1) they lie between two arterioles; (2) the wall is a double membrane, endothelium and epithelium; (3) there is no reabsorption; and (4) the blood pressure is twice that of the other capillaries.

The Tubules

Immediately beyond the expansion of Bowman's capsule, the tubule system commences with the proximal convoluted tubule composed of tall active cells with a narrow serrated lumen. This is followed by the deep straight descending limb of Henle's loop, which is formed by flattened thin cells surrounding a relatively wide lumen. The ascending portion of the loop is formed of cuboidal cells, which pass into the distal convoluted tubule, with its taller cells not unlike those seen in the proximal segment. This system finally empties into the collecting tubule, which carries the urine towards the renal pyramids.

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The Vascular Supply

The functional portion of the blood supply to the nephron arises in the afferent arteriole which shows the three layers of the typical arteriole, which changes immediately adjacent to the glomerulus with the substitution of epithelioid cells for the muscle fibers (the juxtaglomerular apparatus). A similar change occurs in the efferent arteriole immediately distal to the glomerulus. These cells are thought to swell and constrict the lumen, when stimulated, being more capable of prolonged constriction than muscle fibers. The efferent arteriole then breaks down to form a typical capillary bed which enmeshes the entire tubular system before draining into the venous system.

This description of the vascular distribution applies to those glomeruli which lie in the outer two thirds of the cortex. Trueta and his associates have described the juxtamedullary glomeruli in which the efferent arteriole divides into two or more vasa recta which pass deeply into the medulla forming loops parallel to Henle's loop. The inference is that the tubular system in these nephrons is not intimately surrounded by capillaries, and homeostasis is not the rapid active function that occurs in the outer cortical nephrons.

The Interstitial Tissues

These are typical areolar tissues which have little significance except in disease processes, particularly the infective type, in which the inflammatory processes lead to increased pressure about the nephron with resultant mechanical obstruction.

Physiology of the Nephron

This commences with glomerular filtration which is a purely physical function determined by the high hydrostatic pressure in the capillaries, opposed by the oncotic pressure of the plasma

proteins, the interstitial tissue pressure and the tubular fluid back pressure, which provides a filtration pressure of approximately 35 mm. of mercury Hg. This filtration pressure is changed by:

I. Hydrostatic Changes
   A. Arterial pressure changes.
   B. Changes in the myoepithelial cells of the juxtaglomerular apparatus.
   C. Resistance of the efferent arteriole.
   D. Increased venous pressure.
   E. Increased renal intrapelvic pressure.
   F. Increased interstitial pressure.

II. Hemodynamic Changes
   Changes in oncotic pressure due to alteration in the plasma protein levels, that is. hemodilution and hemoconcentration.

III. Glomerular Disease
   A. Glomerulonephritis.
   B. Kimmelstiel-Wilson syndrome.
   C. Amyloid disease.
   D. Disseminated lupus erythematosus.

Tubular Function

The physical nature of the glomerular filtration is such that loss of this filtrate unchanged is incompatible with life. It is by virtue of tubular function that a delicate balance in homeostasis is obtained.

I. Proximal Convoluted Tubule
   This is the site of obligatory reabsorption of glucose, water, sodium, bicarbonate, chloride and ascorbic acid. The degree of absorption is a function of the rate of flow past the cells, and constitutes a gross replacement of the essential products.
   These same cells excrete penicillin, paraaminohippurate. Diodrast, creatinine and phenolsulfonphthalein, but this excretion is somewhat limited by the concentration of the substance, as well as the combined concentrations of the various substances. This phenomenon is employed in blocking penicillin excretion with caronamide.

II. The Thin Segment
   This simple histologic structure suggests that continuation of obligatory reabsorption occurs in this portion permitting equilibrium with the adjacent interstitial fluid by simple osmotic adjustment. It is with this simple diffusion of water across the membrane that the nonprotein nitrogen products are reabsorbed to approximately 40 per cent of that excreted in the glomerular filtrate.

III. The Distal Convoluted Tubule
   This terminal portion of the nephron constitutes an endocrine target organ, and it is here that the delicate homeostatic balance is achieved. There is a facultative reabsorption of water, sodium, chlorine and bicarbonate, under the influence of the pituitary antidiuretic hormone and a factor secreted by the adrenal cortex.
   A. The posthypophyseal-hypothalamic complex is stimulated to secrete its hormone by an increase in the plasma osmotic pressure. The hormone acts on the cells of the distal tubule to reabsorb a hypotonic solution and to leave a small volume of hypertonic urine.
   B. The adrenal cortex secretes a factor which stimulates sodium absorption and is said to prevent excess reabsorption of potassium.

   The distal tubule is also partially responsible for the maintenance of acid base balance and secretes ammonia and hydrogen ions in response to changes in the hydrogen ion concentration of the adjacent interstitial fluids.

   The small moment-to-moment changes in hydrogen ion concentration are corrected by the secretion of hydrogen ions, which is done quickly and effectively by the liberation of the ions from carbonic acid by carbonic anhydrase.

   When a more profound and prolonged lowering in hydrogen ion concentration occurs over a period of several days, ammonia is formed from glutamine and other amino acids and secreted in order to preserve the essential bases such as sodium and potassium.

These tubular functions lend themselves readily to their employment as clinical tests of renal efficiency.

The simplest and most inexpensive test is that of determining the concentrating and diluting ability of the kidney, since, as the tubular function diminishes, the specific gravity of the urine approaches that of the glomerular filtrate and the adjacent interstitial fluids, which is ap-

proximately 1.010 (1.005-1.012). The dilution test may, however, be interferred with by adrenal, hepatic, intestinal, cardiac and neurohypophyseal dysfunction, whereas the concentration test is only interferred with by a receding edema, and is, therefore, almost foolproof as a test of tubular function.

The phenolsulfonphthalein (P.S.P.) test is commonly employed to determine kidney function. This dye is readily excreted by the cells of the proximal convoluted tubules, and therefore the test is not too sensitive, but will give reliable positive results when moderately severe impairment has occurred in tubular function or renal blood flow. Experience has shown that early impairment may be detected more accurately with 15, 30, 60 and 120 minute assessments of the urinary excretion of the dye, in which the 15 minute specimen may be the only one to show diminished excretion. "Humps" in the excretion curve suggest errors in technic, the most common of which is failure to provide an adequate diuresis. Values greater than normal may be encountered in the presence of the increased renal blood flow of acute glomerulonephritis and early essential hypertension.

This test is also subject to error, for its excretion in the urine depends upon: (1) the rate of renal blood flow; (2) the functional capacity of the tubules to extract the dye from the blood stream (normally 50 per cent); (3) the rate of urinary flow through the collecting tubules, pelves and ureters; and (4) the presence of tubular blocking agents, such as para-aminohippurate and Diodrast. It, therefore, must be assessed in the light of other tests, therapy, general vascular disturbances and postrenal obstruction.

Pathology

It becomes apparent that disease processes may effect one or more of these components of the functioning nephron, either structurally or functionally, and often both.

The glomerular filtrate may be increased by an increased permeability or decreased by obliteration of the capillaries, thus reducing the filtration surface.

Proteinuria

Perhaps the most important clinical feature of glomerular dysfunction is the presence of protein in the urine.

Normal urine has approximately 200 mg. of protein per day, which is a little less than a trace and is due to desquamation of cells lining the nephron and urinary tract.

It has been shown that capillaries allow protein to pass through into the interstitial tissues. In the subcutaneous fluids this amounts to about 0.1 per cent, in the renal fluids to about 4 per cent, and in the liver up to 7 per cent. The glomerular capillaries, however, by virtue of their double membrane, are more retentive than other capillaries.

Studies on hemoglobin, which has approximately the same sized molecule as albumin, show that it is filtered through the glomerulus at a rate approximately 3 per cent of the water-soluble filtrates. Osmotically this amount is negligible, but even such a small leak would amount to 20 Gm. of protein per day.

With an essentially protein-free urine it is evident that there must be a tubular reabsorption of protein, and it has been estimated that the maximum tubular reabsorption capacity for colloids is approximately 3 mg. per minute. Since there is a slow transfer from the cell to the interstitial fluid, the capacity is depressed with prolonged reabsorption or high glomerular filtration of proteins. That is, the normal virtual absence of protein from the urine may be attributed to extreme retentiveness of the glomerulus and the tubular capacity for colloid reabsorption, and proteinuria is due to glomerular leaks or tubular failure. Studies have shown that the glomerular lesions are by far the most common cause of proteinuria. Some authors believe that the loss of protein in the urine is an expression of the kidney's attempt to compensate for reduced glomerular filtration surface by an increase in the glomerular permeability. The belief is supported by the observation that intravenous calcium gluconate, which decreases capillary permeability, will decrease the degree of proteinuria, but is accompanied by an increase in the nonprotein nitrogen level in the blood.

Casts

A second important clinical finding associated with glomerular lesions and proteinuria is the formation of casts. These are cylindric masses of coagulated protein, possibly containing cellular debris, and usually formed in the distal tubules and collecting tubules. The formation of a cast is dependent upon:

I. The concentration and nature of the protein.

II. The hydrogen ion concentration of the tubular fluid, which usually changes from alkaline to acid in the region of the distal tubule.

III. The concentration of the water-soluble substances such as urea and electrolytes, which appear to have a dispersive effect inhibiting cast formation the greater the concentration.

IV. The concentration of a nondialyzable substance, called the X-body, which is related to chondroitin sulfuric acid, and is secreted by the tubular cells.

The types of casts are:

I. Hyaline — formed directly from the protein lost in the glomerular filtrate.

II. Epithelial — formed from the desquamated cells of the nephron.

III. Blood casts — formed by blood cells entangled in fibrin, which is converted from fibrinogen by the presence of calcium in the glomerular filtrate and histamine-like substances from the tubule cell breakdown. Such casts are present in glomerulonephritis, embolic nephritis, lupus erythematosis and periarteritis nodosa, and are of important clinical significance since they are unequivocal proof of parenchymal bleeding, whereas hematuria may have occurred at any point in the urinary tract.

Such casts, of course, are frequently mixed since the three basic elements are often found together in renal disease.

Epithelial casts and hyaline casts with cellular debris have some clinical significance since the epithelial elements undergo progressive disintegration which passes through a coarsely granular stage, a finely granular stage and finally a stage of homogeneous waxy appearance with a high refractive index. These stages, therefore, represent a rough index of the flow of urine within the nephron in which they were formed, hence the presence of waxy casts after periods of anuria and renal ischemia.

Fatty casts may also be seen, which contain fat droplets derived from desquamated tubule cells which have undergone fat phanerosis, indicating the presence of chronic tubular disease.

The diameter of a cast is of some significance since the distal convoluted tubule is fairly uniform, but the collecting tubules gradually increase in diameter as they approach the renal pyramid. Many nephrons empty into a single collecting tubule, which unites with other such tubules to converge on the ducts of Bellini. Within this system the rate of flow of urine reaches its maximum within the kidney parenchyma. The formation of a cast within this system is therefore relatively difficult, and when a broad cast is formed, it signifies gross stasis involving many nephrons, hence the name "renal failure" casts since they herald renal failure.

Narrow casts, on the other hand, indicate swelling of the tubular cells, under some toxic or degenerative influence, which has constricted the tubular lumen.

These casts must be centrifuged and examined as soon as possible after excretion, or the urine acidified if there is to be delay in examination, since they dissolve in alkaline urine, and will, of course, disappear in those urines allowed to stand for a few hours and be alkalinized by bacterial action.

A discussion of proteinuria should not be left without reference to the massive albuminuria associated with the nephrotic syndrome, in which 5 to 10 Gm. of protein is commonly lost daily, occasionally rising to as high as 60 Gm.

Such a high loss of protein would suggest that glomerular filtration has been increased, yet no glomerular pathology has been noted in lipoid nephrosis; and in those diseases in which glomerular damage ultimately occurs, the nephrotic syndrome is encountered when the disease process has not yet encroached upon the filtering area. Furthermore, at this stage, kidney function tests appear to be excellent.

Some workers have blamed tubular function for the disorder, and undoubtedly the tubule cells show swelling of considerable degree and vacuolization, especially in the proximal convoluted tubules. Since, however, no tubular secretion of albumin has ever been demonstrated, the simple blocking of the protein reabsorptive process by excess protein is not sufficient to account for losses of protein which may far exceed the maximum glomerular filtration of the normal kidney.

Others have blamed the plasma proteins and claim that there is a lowering of their oncotic pressure. All studies, however, have failed to reveal any abnormality in the proteins in the plasma or in the urine.

The facts do not preclude the possibility of a functional change in glomerular filtration, which is supported by the work of Lange, Weiner and Boyd, who demonstrated a great increase in capil-

lary permeability throughout the body, and showed that the appearance and disappearance of edema closely parallels the change in capillary permeability.

The nephrotic edema has been explained on the basis of the secondary (or possibly primary) hypoproteinemia. This edema, however, will persist in spite of excessive protein in food, blood transfusions and concentrated serum albumin; yet it will recede with great loss of weight, long before the plasma oncotic pressure returns to normal. The recession of edema, however, has been related, along with proteinuria, to the change in capillary permeability.

It is noteworthy that plasma complement is lost during excessive or prolonged proteinuria, leading to a loss of resistance to infection.

Hematuria

The causes of hematuria of parenchymal origin have been discussed in relation to the formation of blood casts, but it is important to recall that clinically significant amounts of blood may not be detected by gross inspection or by the benzidine or guaiac tests, yet may be readily appreciated beneath the microscope. The importance of the chemical tests is in the detection of hemoglobin in those urines in which red cells are not seen. The presence of hemoglobin in the urine may be associated with intravascular or intraurinary hemolysis. The latter may be distinguished by the presence of "ghost" cells.

Hypertension

One of the most common clinical findings is hypertension. The most popular theory of the production of renal hypertension is that ischemia of the renal parenchyma produces, from its tubule cells, a proteolytic enzyme, renin, which splits an alpha globulin, produced in the liver, to form angiotonin or hypertensin, which reduces the oxygen requirements of the nephron, increases the force of the heart beat, raises the blood pressure and preferentially constricts the efferent glomerular arteriole.

That this is an oversimplified theory is suggested by the work of Grollman, Muirhead and Vanatta, who performed bilateral nephrectomy in dogs producing a severe hypertension, and found that a pronounced proliferation of the eosinophilic cells of the anterior pituitary occurred, with an absolute or relative diminution of the number of chromophobe cells and basophile cells. Further evidence of an endocrine involvement was shown by Heinbecker, who performed unilateral nephrectomy in dogs to produce a "work hypertrophy" of the remaining kidney. He found that he could prevent this hypertrophy by removing the anterior pituitary or the adrenal cortex. From these findings he postulated that renin, secreted by the overloaded or relatively ischemic kidney, stimulates the eosinophils of the anterior pituitary to secrete an adrenocorticotrophic hormone which, in turn, stimulates the adrenal cortex to secrete a factor promoting the hypertrophy of the kidney. Selye demonstrated that an unidentified adrenocortical steroid is capable of producing profound renal damage. Page suggested that angiotonin, while increasing the renal blood flow, induces an increased loss of urinary sodium, which stimulates the adrenal zona glomerulosa to secrete its sodium-retaining factor as well as the steroid suggested by Selye, which produces nephrosclerosis, thereby retarding the renal blood flow and creating a vicious circle.

It has also been demonstrated that intermittent overactivity of the sympathetic nervous system and the adrenal medulla may produce renal ischemia. The association of the hypothalamus with the pituitary and the sympathetic nervous system suggests that this complex pituitary-adrenal-renal dysfunction may also be the mechanism in the production of essential hypertension, which is so often associated with "high tension" living and may be initiated via the corticohypothalamic pathways.

It has also been suggested that renal hypertension may possibly be a deficiency disease. Grollman thought that the normal kidney tends to maintain normal blood pressure by inactivating pressor agents, which may be supported by the observation that the kidney contains a higher concentration of angiotonase than any other tissue. Findley suggested that the renal tubule secretes "something" which depresses the functional activities of the eosinophile-adrenal-cortical complex, and that in the absence of this factor the eosinophilic proliferation proceeds unchecked to stimulate the production of the nephrosclerotic steroid from the adrenal cortex.

Renal Insufficiency

All grades of renal insufficiency occur, but the ultimate manifestation is the appearance of uremia, a clinical syndrome associated with renal failure and a consequent disturbance of the body chemistry with loss of normal function.

The syndrome may be acute or chronic, and caused by the following:

Prerenal — circulatory failure or dehydration.

Renal — vascular, parenchymal or interstitial damage.

Postrenal — obstruction of the urinary out flow. The clinical picture of renal failure is specifically due to:

1. Decrease in glomerular filtration.
2. Loss of tubular function.
3. Loss of acid base balance.

It may be manifested by some or all of the following signs and symptoms:

1. General: headaches, weakness, dizziness, apathy which may progress to coma, visual disturbances, loss of weight and anemia.
2. Gastrointestinal: nausea, vomiting, diarrhea, anorexia and stomatitis.
3. Neuromuscular: twitching, hiccough and reflex changes.
4. Skin: itching, petechiae and uremic frost.

Acute Renal Failure

The two most common forms are acute glomerulonephritis and lower nephron nephrosis.

Lower Nephron Nephrosis

This condition is a focal degeneration and necrosis of the ascending limb of Henle's loop and the distal convoluted tubule, although occasionally the proximal convoluted tubule will also be involved, whereas the glomerulus is intact. The syndrome is precipitated by shock, sulfonamides, crush syndrome, intravascular hemolysis, transuretheral resections and postoperative urinary suppression, hepatic failure and acute febrile diseases, especially those associated with great dehydration.

These etiologic factors are associated with either prolonged collapse or mechanical obstruction.

1. The obstructive form is encountered in sulfonamide precipitation within the tubules by an acid, diminished urine.
2. The tubular dysfunction form is the end result of the ischemic process which is believed to produce total reabsorption by the tubules.

It seems that damage to the tubular walls destroys the specific reabsorption which takes place in the normal tubule. The glomerulus forms an ultrafiltrate normally, but during the passage through the damaged or necrotic tubules all the glomerular filtrate is reabsorbed, because the tubular epithelium has been transformed into a nonspecific dialyzing membrane. The colloid osmotic pressure of the circulating plasma proteins draws all the water present in the lumen of the necrotic tubules back into the blood stream with resultant anuria.

Clinical Picture

There are three clinical phases in lower nephron nephrosis:

I. The period of initial injury to the kidney associated with hypotension, vascular collapse or mechanical precipitation of intratubular crystals.

II. The onset of oliguria or anuria, and if uncontrolled, the appearance of clinical and laboratory evidence of uremia, and possibly other electrolyte imbalances, such as hyperchloremia, hypernatremia and hyperkalemia.

III. The recovery phase with the onset of progressive diuresis, during which there is polyuria with hyposthenuric urine, which may lead to excessive loss of sodium and chloride, and water.

Treatment

I. First Phase

The initial step is the restoration of normal blood volume and blood pressure — prophylaxis. Early alkalinization of the urine is usually recommended. BAL (British antilewisite) may be used in heavy metal poisoning. Treatment with antibiotics other than sulfonamides depends on specific causes.

II. Second Phase

A. Nutrition is maintained with a high caloric, high vitamin diet designed to reduce the endogenous protein breakdown to a minimum, thereby preventing any undue elevation of the nonprotein nitrogen. Borst suggested a diet of 200 Gm. of sugar and 200 Gm. of butter as an ideal daily intake. Unfortunately, as might be anticipated, this diet is wholly unpalatable and causes nausea and vomiting. It provides approximately 2,250 calories and only 1.5 Gm. of protein.

B. Fluid balance constitutes the replacement of not more than the total daily fluid loss — insensible loss (fever, dyspnea), loss in stool and urine, and loss in vomitus. The total daily requirement varies between 750 and 1,500 cc. depending upon

the body weight, climate, season and presence of those factors which aggravate the insensible fluid loss. Changes in weight are a good index of the fluid balance.

It should be remembered that foods have a water of oxidation, being roughly 1.0 Gm. of water from each gram of fat, and 0.5 Gm. of water from each gram of carbohydrate or protein. The Borst diet carries approximately 30 cc. of water, but its water of oxidation amounts to approximately 300 cc. of water. It seems that this failure to restrict fluids is the largest single cause of death in lower nephron nephrosis, and therefore, it would appear to be a wise practice to restrict fluids whenever there is any doubt as to the cause of anuria.

C. Electrolyte balance resolves itself into frequent checks upon the serum levels of sodium, potassium, chlorine, the hematocrit reading and the alkali reserve (CO_2 combining power). It is no doubt apparent that there will be no loss of these electrolytes except through disturbances in the gastrointestinal tract, such as vomiting and diarrhea, or by excessive sweating. Insensible perspiration carries only negligible electrolytes with it. It must be borne in mind, however, that there is an inevitable endogenous breakdown of protein from the body from which potassium will be freed into the blood stream and will elevate it beyond its normal 4 to 5 milliequivalents per liter, to levels at which the hyperpotassemic syndrome manifests itself with the onset of:

1. Listlessness and mental confusion.
2. Numbness and tingling of the extremities with a sense of weakness and heaviness of the legs.
3. Cold gray pallor.
4. Peripheral vascular collapse.

The electrocardiogram affords a relatively early indication of hyperpotassemia, which first shows its toxic effect upon the myocardium at around 6 milliequivalents and progresses to complete heart block when it has risen to 10 milliequivalents or above. The progressive electrocardiographic changes are:

1. Peaked T waves (increased vertical amplitude and a narrowed base).
2. Increase in the amplitude of R and S waves.
3. The appearance of auriculoventricular and intraventricular blocks.
4. The loss of P waves—auricular standstill.
5. Depression of the S-T segment, and the T wave originates directly from the S wave.
6. The QRS and T waves become smooth biphasic curves due to the progressive delay in ventricular conduction.
7. The total arrhythmia with cardiac arrest in diastole.

The prevention of hyperpotassemia of course is a function of the dietary management, not only by giving a low protein diet, which is in itself a low potassium diet, but by preventing the undue breakdown of the body proteins which liberate approximately 2.5 Gm. of potassium for every gram of nitrogen that is released. When excess potassium accumulates in the blood stream, however, it is imperative to treat the condition actively to avoid the dangerous cardiac dysfunction.

It has been shown that calcium combats the toxic effects of potassium and tends to increase the frequency of ventricular contractions. Its effectiveness, however, is less than a similar use of sodium. It would appear that there is a rough reciprocal relationship between sodium and potassium and that the use of parenteral or oral sodium will correct or reduce the manifestations of hyperpotassemia. Desoxycorticosterone is also said to reverse the effects of potassium toxicity and to prolong life. The danger, however, of giving sodium in the presence of anuria is most apparent, but in those instances in which there is a concurrent hyponatremia, the use of sodium is positively indicated.

Other clinical subterfuges have been suggested:

1. Testosterone is thought to effect the positive nitrogen and potassium balance by a retention of these elements within the cells, thus preventing their rapid release into the extracellular fluids.
2. With regard to glucose and insulin, it has been demonstrated that potassium is carried out of the extracellular fluid into certain of the tissues by the process of glycogenesis. This form of therapy is said to be one of the most consistent and reliable methods of controlling hyperpotassemia.
3. The use of the artificial kidney and methods of large and small bowel irrigations are reportedly most efficient, but require frequent assessment of the serum electrolyte levels to prevent their excessive reduction.
4. It is of interest that the gastric secretions may rise as high as 40 milliequivalents (eight times that of the serum), and are normally reabsorbed through the intestine. Simple gastric suction might reduce the serum level of potassium, and permit easy assessment of the other electrolytes, which could be replaced with the fluid lost, after the method of the Mayo fluid balance team.

III. Third Phase

During the recovery phase there is a progressive polyuria associated with a loss of electrolytes which would tend to create fluid and electrolyte deficiencies, the reverse of those occurring in the second phase. They are, of course, corrected by suitable replacement therapy.

Treatment then is essentially the maintenance of homeostasis during the 5 to 10 day period in which the tubules begin to regenerate, and during a similar period of recovery. That recovery is possible is due to the fact that the tubules are of epithelial origin and are capable of regeneration without scarring, whereas glomeruli, which are mesenchymal in origin, are incapable of regeneration and, following comparable damage, progress to scarring and hyalinization. The acute phase of glomerulonephritis may produce a similar anuric picture, but of course, with recovery, there will be glomerular lesions.

In most cases of lower nephron nephrosis the patient will recover provided:

A. The circulation is not overloaded by excessive fluid intake.
B. The nutrition is maintained in such a way that there is no undue accumulation of toxic metabolic products.

Chronic Renal Failure

The presence of chronic renal disease, such as chronic glomerulonephritis and chronic pyelonephritis, leads to a progressive loss of function, and like the heart, the kidney ultimately decompensates, and renal insufficiency appears. This usually occurs when the glomerular filtration surface is reduced to approximately 60 per cent with a comparable failure in tubular function, which results in the inability to concentrate, and failure of the tubular power of reabsorption and secretion.

The reduced glomerular surface reduces the total glomerular filtration, but the failure to concentrate within the tubules results in polyuria, at least until the glomerular filtrate is reduced so low that the urinary output falls below 500 cc. daily, when a state of oliguria exists.

If the proximal segment fails to reabsorb its share of the glomerular filtrate, a large quantity of filtrate passes through the distal segment, and the resultant increased rate of flow reduces the time during which water reabsorption and concentration of the filtrate can occur. In consequence, urine volume increases and urine concentration diminishes. Anuria or oliguria appears when filtration ceases altogether, or becomes so small that reabsorption is almost complete.

With the reduced filtration there is a tendency to retain those products which are normally excreted in the urine. The extent to which the various substances are retained is proportional to the degree of their concentration in normal urine; that is, urea, which is normally concentrated some 70 times, is the first to be retained, creatinine, which is normally concentrated approximately 60 times, is the next to follow, and then uric acid, concentrated to approximately 30 times. Elements such as chloride, calcium and sodium, which are scarcely concentrated at all in normal urine, are the least affected and do not accumulate in the blood, while potassium, phosphate and sulfate occupy an intermediate place.

The retention of various products within the blood stream, chiefly the nonprotein nitrogens, is thought to be the cause of the physical signs and symptoms of uremia.

Retained Products

I. Urea

Urea is produced from the breakdown of either protein ingested or constituents of the body tissues, and is the first to rise in the serum with renal insufficiency. It is also the easiest and most reliable index of retention. There is little or no parallelism, however, between the level of urea and the uremic symptoms. Experimental evidence shows that the amount of urea encountered in patients with uremia is insufficient to produce a primary toxic action and that relatively large amounts are required to produce similar symptoms. The excretion of urea through the gastrointestinal tract is broken down by bacterial action to form ammonia which causes gastritis, enteritis and colitis, with resultant vomiting, diarrhea and the uremic odor.

Urease in the saliva also reduces the urea to ammonia within the buccal cavity and results in stomatitis. Its excretion in the sweat becomes apparent as uremic frost.

II. Creatinine

Creatinine is derived from the breakdown of creatine, and rises later in the blood stream, not only because of its lesser concentration, but also because of its partial excretion through the tubules. An elevation of the serum creatinine is therefore an index of more profound damage than that encountered with elevation of urea alone. Creatinine is associated with muscle metabolism, and during uremia there is evidence of muscle wasting.

III. Phenols

These substances are formed from the catabolism of the amino acids tyrosine, tryptophane and phenylalanine within the body and possibly absorbed from the gastrointestinal tract, where they are formed by bacterial action. Experimental elevation of the phenols produces uremic symptoms, especially those of weakness, apathy, disorientation, stupor and coma, during which time it has been noted that the cerebrospinal fluid level is also elevated.

Bone marrow studies were carried out in cases of renal disease by Callen and Limarzi, who found that in most of the patients with chronic nephritis the bone marrow was hypercellular, involving the myeloid and megakaryocytic cells. They noted that erythroid hyperplasia occurred only when the nonprotein nitrogens rose above 150 mg. per hundred cubic centimeters. They concluded that the anemia of azotemia is likely due to a chronic toxic inhibiting effect on the bone marrow, and that the degree of anemia depends on the degree of azotemia. Other workers suggested these aromatic phenols have a depressing effect on the bone marrow which may produce a hypoplastic bone marrow or maturation arrest, resulting in anemia and platelet reduction which causes the hemorrhagic tendencies often observed in patients with uremia. In the opinion of others, absorption of iron from the gastrointestinal tract is depressed and is responsible for the anemia.

IV. Guanidine

Guanidine, believed to be an antagonist of calcium, has been shown to produce gastrointestinal effects, such as nausea, vomiting and diarrhea, at low levels, and neuromuscular symptoms such as muscle twitching at high levels of serum guanidine. In spite of the fact, however, that guanidine produces a picture almost identical with that of uremia, the doses required to produce the picture in dogs are considerably higher than the levels found in humans with comparable symptoms.

Polyuria

The onset of polyuria with early renal insufficiency has been shown to be due to glomerular-tubular imbalance. Some, however, believe that the inability of the kidney to produce hypertonic urine elicits a compensating increase in the volume of urine so that the total quantity of solids excreted does not fall. Others believe it to be incidental rather than corrective. Nevertheless, it is fortunate that polyuria does occur in order to prevent further reabsorption of the toxic metabolites through the defective tubules.

It has been shown that on a sharply restricted fluid intake kidneys with a normal function can excrete 15 Gm. of solids in 250 cc. of urine, whereas with a poor kidney on a restricted intake only 5 Gm. of solids can be excreted in 1,000 cc., of which 750 cc. must be drawn from the extracellular fluids and would rapidly produce dehydration, if not checked.

The same impaired kidney on a high fluid intake can excrete 15 Gm. of solids in 2,000 cc. of urine, without any retention of solids or dehydration, that is, the impaired kidney requires almost 10 times the amount of urine water required by the normal kidney to excrete an equal amount of metabolic waste material.

It has been shown that the maximum specific gravity obtained in the presence of dehydration or oliguria or by concentration test is a close clinical index of the amount of urine water required to eliminate a given amount of solids, for example 40 Gm., the daily average excretion.

Specific Gravity	Minimum Urine Water	Optimum Urine Water
1030	500	1,500
1015	1,500	2,500
1010	2,000	3,000

If the minimum amount of water is not available, the extracellular fluids are drawn upon; dehydration ultimately occurs, defeating the advantage of the polyuria, and the solids are retained.

Needless to say, this polyuria, which reflects the tubular dysfunction, also has its disadvantage, namely, the loss of essential electrolytes, which under normal circumstances would have been reabsorbed.

I. Sodium

Glomerular-tubular imbalance with tubular diuresis shortens the time of contact between the filtrate and the tubule cells in the proximal and distal segments in which sodium conservation is usually effected, with a resultant inadequate sodium reabsorption. This is further aggravated by failure of the mechanism of the renal acid base balance, which normally substitutes ammonium and hydrogen for sodium in the distal tubules. The loss of sodium is accompanied by a loss of chloride ions, as well as bicarbonate ions which are the volatile ionic fillers in the acid base balance.

The loss of salt over a long period of time, or a shorter period of time if anorexic and gastrointestinal disturbances are present, results in hyponatremia and hypochloremia, which are manifested as the low salt syndrome:

A. Lassitude, weakness, headache and anorexia.

B. Apathy, light headedness, nausea and vomiting, and abdominal or muscle cramps.

C. Stupor, fall in blood pressure, with syncopal attacks, tachycardia and shocklike state.

It is noteworthy that in spite of water loss which proceeds to dehydration and oliguria, there is an absence of thirst.

The hypochloremic state is also manifested by a depression in hydrochloric acid formation in the stomach. Schroeder believed that the serum concentration of sodium and chlorine is associated with the ability of the kidneys to excrete nitrogen, and that hyponatremia and hypochloremia cause a decreased renal blood flow with increased retention of nitrogenous products — so-called "hypochloremic uremia."

Normally the strongly acid metabolites, the sulfates and phosphates, which are derived from the breakdown of phospholipids and protein, are neutralized within the body by sodium derived from the body sodium bicarbonate and from dibasic sodium phosphate, and then within the kidney tubules the sodium is reabsorbed and replaced by ammonium or hydrogen according to the ionic exchange mechanism described by Smith.

With renal insufficiency not only does the ionic exchange mechanism fail because the tubule function is lost with a resultant loss of body base, but there is a retention of these acid radicles which ultimately exhaust the phosphate and bicarbonate buffer systems, and the patient becomes acidotic.

II. Potassium

Potassium is normally reabsorbed most efficiently by the renal tubules, and as the reabsorption power diminishes, it is usually balanced by a reduced filtration. Although potassium is excreted in the urine roughly in proportion to the volume of urine, the loss is adequately balanced by the excessive dietary intake. As anorexia and reduced food intake occur, however, there is a relatively slow, but progressive, loss of potassium ion from the body depending upon the degree of polyuria. With the onset of vomiting and/or diarrhea potassium is lost rapidly, and the syndrome of hypopotassemia appears:

Weakness and hypotonicity of:

A. Skeletal muscles leading to flaccid paralysis.

B. Respiratory muscles producing dyspnea and cyanosis.

C. Gastrointestinal musculature with abdominal distention, nausea and vomiting.

D. Myocardium with dilatation and failure.

The influence upon the myocardium may be determined by the electrocardiographic changes:

A. Prolongation of the QT interval.

B. Lowering of the T waves and possible inversion.

C. Prolongation of the T waves.

D. Depression of the S-T segment.

E. Possible inversion of the P waves.

F. Extra systoles and auriculoventricular block.

There is apparently only approximate parallelism between the cardiac effect and the degree of hypopotassemia, and therefore, it is wise to be on the lookout for the syndrome as considerable cardiac damage may be inflicted by only a moderate depression of the potassium level.

III. Calcium and Phosphorus

The loss of calcium associated with the polyuria tends to reduce the level of ionized serum calcium, unless there is an adequate intake of calcium in the food. The onset of uremic gastrointestinal signs will result in depression of the intake and cause a hypocalcemia. Some workers believe that there is a failure of the intestinal wall to respond to vitamin D during uremia, with a consequent failure of calcium absorption. There is usually a higher dietary intake of phosphorus than of calcium, and it is thought that the absorption of calcium may also fall because of the precipitation of calcium phosphates.

The rough reciprocal relationship which exists between phosphorus and calcium tends to be reversed in uremia, not only because of the reduced calcium absorption, but also because of the increase of inorganic phosphates associated with endogenous tissue breakdown. The reversal of the phosphorus-calcium ratio in renal insufficiency is thought to stimulate parathyroid hyperplasia and the production of increased amounts of parathormone in order to mobilize calcium from the bone and to correct the hypocalcemia — the mechanism also believed to exist in "renal rickets." It has not been adequately demonstrated, however, that there is any increase in parathormone in uremia, and the form of hyperplasia is different from that seen in primary hyperparathyroidism, involving the "water-clear" cells rather than the "chief" cells. Others believe that the acidosis of uremia is responsible for the calcium mobilization from the bone. The presence of hypocalcemia is believed to cause the muscular twitching observed in patients with uremia. Some workers have demonstrated that there is an increased inorganic phosphate encountered in the cerebrospinal fluid of dogs showing uremic muscle twitching, but it has also been demonstrated that there is a corresponding decrease of calcium in the cerebrospinal fluid.

Experimental hypocalcemia has been shown to have a stimulating influence upon the central nervous system, which may be reversed by the intravenous injection of calcium salt, or by the antagonism of aromatic phenols. Guanidine is also thought to be an antagonist of calcium. The muscular twitching in human subjects with uremia has also been relieved by parenteral calcium.

It would appear then that the neuromuscular disorders of uremia are due to the unbalanced antagonism of a low serum calcium to elevated levels of phenols and/or guanidine.

This condition may be prevented by the ingestion of adequate calcium, and a regimen of aluminum hydroxide which precipitates the phosphates ingested in an insoluble form within the intestinal tract.

Treatment of Chronic Renal Insufficiency

It would appear from these arguments that the management of chronic renal insufficiency depends upon the maintenance of a high urinary output, the prevention of toxic metabolite retention and the replacement of the excessive loss of electrolytes in the urine.

I. Fluids

The criterion of adequate fluid intake is a urinary output sufficent to excrete the non-protein nitrogen metabolic products without any residual retention in the blood stream. The required urinary output may be deter-

mined by the serial estimations of the blood urea nitrogen, or by reference to the scale of optimum urinary outputs related to the specific gravity given previously.

II. Nutrition

An adequate caloric intake is required, best given in a high carbohydrate, moderate fat, low protein diet, the protein being sufficient to meet the body's anabolic demands. This will be approximately 1 Gm. of protein per kilogram of body weight. Such a diet will automatically provide a neutral or even alkaline ash. It will also reduce the amount of excessive protein breakdown products, that is, the nonprotein nitrogens, thereby reducing the required quantity of urine water for their excretion. In other words it allows the kidney to compensate on a lower volume of urine.

III. Electrolyte Replacement

No restriction must be placed on the intake of sodium chloride or calcium-containing foods. The latter should be facilitated with vitamin D supplements and doses of aluminum hydroxide with each meal, for example, in milk.

In the presence of congestive failure, however, emphasis must be placed upon the treatment of the cardiac decompensation and great care taken in the administration of sodium.

Patients with pronounced polyuria may be benefited by a supplement of sodium chloride, for example, 1 Gm. of enteric-coated sodium chloride three times a day. When acidosis exists, an addition of 1 to 2 Gm. of sodium bicarbonate three times a day will assist materially.

IV. Complications

If these general rules of management are adhered to, the more disturbing manifestations of uremia, particularly the gastrointestinal disturbances which lead to the various electrolyte imbalances, may be avoided. When electrolyte imbalances occur, the degree of deficiency of each electrolyte should be determined and accurate replacement therapy instituted accordingly.

Nausea, vomiting and diarrhea must be combated aggressively and sufficient parenteral fluids and electrolytes given parenterally to ensure elimination of the retained products believed to be the cause of these disturbances.

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ABSTRACTS OF MEDICAL ARTICLES

Glaucoma Following Occlusion of Central Retinal Artery. By Curtis D. Benton Jr., M.D., A. M. A. Arch. Ophth. 49:280-284 (March) 1953.

Two cases are reported in which a sudden severe unilateral glaucoma developed a few weeks after occlusion of the central retinal artery in the affected eye. The clinical features in these cases parallel in many aspects those of glaucoma following occlusion of the central vein. Pathologic findings in the one eye that was enucleated are described. A fibrovascular peripheral anterior synechia, similar to, but less extensive than, that found in hemorrhagic glaucoma following occlusion of the central retinal vein is found in the iridocorneal angle. This clinical picture is of extremely rare occurrence; there have been no reports of the condition since 1930, and current textbooks seldom make mention of it. The remarkably consistent findings, however, in these and previously reported cases justify its inclusion with the secondary glaucomas in the author's opinion.

The Effect of Age on the Carbonic Anhydrase Activity of Bovine Lenses. By Theobald Reich, M.D., and Raymond W. Healy, M.D. Am. J. Ophth. 36:500-503 (April) 1953.

How age affects noncataractous lenses with regard to their carbonic anhydrase activity had not been investigated until an investigation was made which is here reported. This study was undertaken in an attempt to supply this information on the basis of carbonic anhydrase activity determinations of young, adult and old bovine lenses.

In determining the carbonic anhydrase activity of homogenates prepared from these noncataractous bovine lenses, a modification of the colorimetric procedure of Trethewie and Day was used. It was concluded that the process of aging did not alter the carbonic anhydrase activity of bovine lenses significantly.

Use of the Plastic Intravenous Catheter for Multiple and Massive Transfusions and Prolonged Intravenous Fluid Therapy. By Donald W. Smith, M.D., F.A.C.S., R. S. Sappenfield, M.D., and W. J. Fink, M.D. Surg., Gynec. & Obst. 95:775-777 (Dec.) 1952.

With the increasing use of massive and multiple blood transfusions and parenteral fluid therapy, improved methods for their rapid and continuous administration are necessary. The authors are of the opinion that the plastic intravenous catheter helps to meet these requirements, but that it has not been as generally employed as is justified. It is their purpose in this paper to review the indications and advantages of the intravenous catheter and briefly to describe the methods of its insertion.

They believe that this valuable adjunct to the success of rapid, massive, and multiple transfusions and continuous intravenous fluid therapy should be immediately available for use as an essential component of the expendable and nonexpendable transfusion administration equipment. Regarded as most suitable for universal use is the previously sterilized polyethylene or polyvinyl plastic intravenous catheter of proper gauge and length, sealed in a glass tube containing 1:1,000 zephiran solution.

Modified Suprapubic Prostatectomy. By Edwin W. Brown, M.D. South. M. J. 46:689-691 (July) 1953.

The operative technic described depicts a combination of the suprapubic and retropubic approach to enucleation of the prostatic adenoma.

A series of cases is reported in which carcinoma was demonstrated microscopically in 18 per cent, and in 27 per cent calculi were present in the bladder at the time of operation. The mortality rate was 3.7 per cent.

Rectal Paraldehyde, a Basal Anesthetic for Children. By Stanley H. Axelrod, M.D., and Charles Stein, M.D. South. M. J. 46:670-672 (July) 1953.

The need for basal anesthesia in children is discussed, and the criteria of a good basal anesthetic agent are presented. Paraldehyde is compared with other basal anesthetics, and its advantages are discussed.

In a series of 87 cases the patients were children ranging in age from 22 months to 11 years and weighing from 21 to 102 pounds. They were all admitted to the pediatric service for surgical procedures of all types but predominantly for tonsillectomy and adenoidectomy. The results in these cases indicate the desired hypnotic effect can be produced by rectal paraldehyde in the majority of patients with a wide margin of safety and without serious complications. It is concluded that paraldehyde as a basal anesthetic deserves renewed interest and popularity.

Correction of Funnel Chest Deformity. By John G. Chesney, M.D., and DeWitt C. Daughtry, M.D. South. M. J. 46:636-639 (July) 1953.

The lesion of funnel chest, its etiology and symptoms, and the indications for and the problems of repair are discussed. The authors believe that when correction is needed, it should be by the more radical technic. Return to essentially normal chest form may be attained by subperichondrial resection of all deformed segments of costal cartilage, division of the xiphisternal attachments and adjacent attachments of costal arch to diaphragm, together wth freeing of the posterior surface of the sternum and high sternal osteotomy. Skeletal traction, utilizing an external bridge, is applied for ten days.

The need for endotracheal anesthesia leads to the conclusion that two and one-half years is the ideal age for intervention, earlier operation being feasible if necessary. Since generalized flattening and asymmetry become well established at about age four, correction should be made before this age, though sternal depression itself is amenable to treatment in adult life.

Simple freeing of xiphisternal attachments and adjacent costal arch from the diaphragm in infants as young as three months of age is not in the opinion of the authors a satisfactory substitute for the more radical procedure.

Proctology Twenty Years Ago and Now. By John Cheleden, M.D. South. M. J. 46:673-678 (July) 1953.

This article reviews briefly the progress of the specialty of proctology, especially during the last 20 years. The scope of the discussion is indicated by the following subheads: anatomy; asepsis, antisepsis, wound healing; anus; hemorrhoids, structure, plastic procedures; pruritus ani; pilonidal cysts; venereal lymphogranuloma; prolonged injectable anesthetics; colon; ulcerative colitis; congenital anomalies; polyps; intussusception; diverticulosis, diverticulitis; carcinoma of the large bowel; diagnosis, examination, referred symptoms.

Tribute is paid to the Section on Proctology of the Southern Medical Association and its role in the dissemination of knowledge pertaining to the specialty, the occasion marking the fifteenth anniversary of its founding.

External Otitis. By Henry E. Branca, M.D. A. M. A. Arch. Otolaryng. 57:310-327 (March) 1953.

Observing that rational therapy is possible only if the clinical picture is more thoroughly understood, the author stresses the need for a more profound study of the clinical appearance of external otitis. He discusses its frequency, age incidence, climatic and geographic aspects, the clinical picture with the variability of the disease in the same patient, the fallacy of trying to divide the disease into separate clinical entities, the nature of the drainage and its diagnostic importance. the frequency of drug sensitivity and its recognition, the cerumen and its theoretic analysis, and the theoretic possibilities. He considers external otitis as primarily an eczema, which is clinically obscured by secondary invaders, and states the theory of neurogenic atrophy of the ceruminous glands.

Despite all the "new therapies," this disease remains a challenge to the otologist, he notes, and states that the present concepts are based on the belief that bacteria are the chief etiologic factors in this disease with fungus as an etiologic agent losing support. The use of the antibiotics, he finds, may indirectly demonstrate the cause of external otitis. Consideration is given to the application of the commonly known therapeutic measures. Conclusions are drawn concerning bacterial

external otitis, otomycosis, and mixed infections, and the difficulty in finding the offending fungus is noted.

Fifteen cases are presented which encompass well all the varied features of the disease.

Change in Electrolytes in a Case of Parathion Poisoning. By Jere W. Annis, M.D., and John W. Williams, M.D. J. A. M. A. 152:594-595 (June 13) 1953.

In reporting a case of severe acute parathion poisoning the authors desired to make known the observed changes in the serum pH and calcium, phosphorus, and potassium levels in the hope of stimulating follow-up studies in order to determine whether the changes in pH and electrolyte concentration are as determinant of the variations in symptoms, the severity of poisoning, and the prognosis as are the changes in the cholinesterase levels of the plasma and cells. They also wished to report the hitherto unreported residual manifestations affecting the central nervous system resulting from anoxia, prolonged unconsciousness, convulsive seizures, electrolytic and pH shifts, and/or severe cholinesterase depression so that these manifestations may serve as a warning of the potential toxic effects of the chemical in nonfatal cases.

They attributed recovery in part to more adequate amounts of blood used and believed these transfusions resulted in the relatively rapid rise in the cholinesterase activity from an extremely low level. Also, they emphasized the advisability of early treatment in parathion poisoning and suggested administration of infusions containing properly adjusted and adequate amounts of calcium and sodium bicarbonate. In addition, they stressed the importance of scrupulous adherence to safety measures and technics in the use of this chemical. While they postulated no new mechanism for the symptomatology of parathion poisoning, they mentioned the possibility that mechanisms do exist in addition to those which have already received attention. Their observations on the electrolytic changes, especially the reversal of the calcium-phosphorus ratio and the prolonged elevation of the potassium level, seem to indicate the possibility of a somewhat different approach to an inadequately understood problem.

Program of Tuberculosis Control in Recent Years. By C. M. Sharp, M.D. South. M. J. 46:695-701 (July) 1953.

Pointing out that steady decrease in tuberculosis death rates in all states has been misleading to the uninformed, Dr. Sharp notes that the tuberculosis problem is by no means completely reflected in death rates. Because of the extraordinary advances in treatment, he depicts tuberculosis as an ever present challenge to the medical and public health professions and their training schools.

Readily subject to prevention and control, this disease remains the most significant chronic fatal disease and carries a higher mortality rate than for any other infectious disease, causing more deaths among young adults than all other diseases combined. It receives too little attention, he contends, in view of its high importance as a preventable disease.

In discussing mass chest x-ray surveys, he mentions examination of 2,024,250 persons by photofluorographic methods in Florida from 1946 through 1951, revealing 23,274 suspicious cases, and on further study 7,489 significant cases. He also discusses the value of culture procedures used routinely in Florida over the use of smear alone, the need for adequate treatment facilities, the phenomenal development of surgery for tuberculosis during the past few years, drug therapy including the use of newer drugs, and the importance of early diagnosis and treatment.

Among defects in tuberculosis control programs he names the shortage of public health nurses and hospital beds and personnel, the need for greater public health education regarding this disease, the seriousness of departure of patients from hospitals against medical advice, and the lack of adequate facilities to solve severe socioeconomic problems.

Despite the many obstacles, Dr. Sharp calls for intensification of the tuberculosis program in view of the encouragement arising from the 50 per cent decrease in the death rates in many sections of the South in the past 10 years and the fact that more persons ill with tuberculosis may be treated than ever before with an excellent chance for recovery.

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From Our President

New Year Greetings

The activities of 1954 begin, in all component medical societies of the Florida Medical Association, under new leadership. To all of you who may be responsible for the carrying out of the functions of a county society I wish to extend greetings for the New Year, and my best wishes for your success. Early organization of your society, the designation of specific functions to officers and committees, and an earnest desire to become thoroughly familiar with your duties and responsibilities will make your term of office less burdensome and productive of better end results.

The central office of the Florida Medical Association and its staff in Jacksonville, and the officers of the Association, stand ready to help you whenever possible. For specific problems, not organizational, its standing committees are also available for consultation with you and for study of your problems.

After eight months in the office of your state president I am becoming increasingly aware of the importance of functioning medical societies in the general practice of medicine. Your officers on the state level, and your Board of Governors, exercise direction over general activities of the Association. Much of the decisive and important actions of organized medicine, and of its influence on the laity, depends in large part on the interest and activity of the county medical society and its member physicians.

Actions on the top level fail if you do not do your part at the county society level. No amount of enthusiasm at the top level can compensate for lack of enthusiasm or lack of cooperation on your level of activity.

To each physician of the Association I extend my best wishes for the New Year, my congratulations and thanks for what you have accomplished during 1953, and my hope that we in Florida will see an increasing interest in the affairs of medicine in 1954.

Frederick K. Herpel

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Suburbia 1954 Lures Physicians

Moving out, Doctor? Many physicians practicing in urban areas are experiencing the urge to escape from the congested downtown districts to the currently popular residential centers or even to the far flung suburbs. In increasing numbers they are following their colleagues who have already yielded to this urge. Here, there and yonder, where formerly one would least expect to see them, modernistic office buildings and clinics meet the eye in or near neighborhood shopping centers.

Standing irresolutely on a busy downtown street corner the other day, a disconsolate businessman replied to a solicitous inquiry: "Why wouldn't I look glum? Just look at this inflamed eye. And I take my lunch hour to go across the street to my eye doctor only to find he has moved to Five Points, two miles out. Now I will have to get my car and drive clear out there."

"The ladies have to have a place to park," was the somewhat facetious rejoinder.

"Do you think women only get sick?" he inquired petulantly.

Yes, the annoyed business man was the victim of a trend. The wonder was that his doctor had not moved more than two miles out. The parade of the picture windows is luring even the physician to fall in line. Where is the city today whose adjacent fields are not surrendering to the onslaught of Suburbia 1954 as they did in 1953? The landscape is being transformed by mushrooming houses, row upon row, some in replica, others of variegated design and finish, but all displaying the badge of Suburbia, the picture window.

This flight to the outskirts is a significant social factor of the times. The movement is worldwide, but particularly in this country suburban populations are increasing by leaps and bounds. During the last quarter of a century the population of the United States has increased by 25 per cent, but the truly rural population has decreased, and the population of cities proper has barely held its own with the general increase. In suburban areas, villages and small towns, however, the population has increased by 75 per cent.

Vital statistics furnish one of the reasons for this shift. The birth rate, increasing in customary fashion at the end of the last war, has not declined as expected although the number of marriages has. It has become the vogue with present day couples to have more children. The average family of 1953, compared with its counterpart in 1929, had one third more first children and two thirds more subsequent children.

Redistribution of income is another major stimulus to suburban growth. The artisan's wage today approximates that of the professional man of 25 years ago. The craftsman and his wife have about as much money to spend as their white collar neighbors. They read the same periodicals, hear and see the same radio and television programs and share more or less the same tastes. They, too, like suburban homes with picture windows.

Other factors which have brought accretions to the suburbs reflect the progress of education and the mechanization of industry, which have reduced the ranks of manual laborers. Too, social security and pensions have created a new class of nonworking residents or part time workers able to own their own homes, many of whom prefer the suburbs to the confinements of the city.

For the convenience of suburbanites the grocer, the pharmacist and others who serve the public have trailed them to easily accessible locations. Doubtless more and more physicians, too, will follow the trend during 1954, finding it both practical and convenient to abandon congested downtown areas and invade the suburbs.

"Doctor Draft Law" Clarifications

Of wide interest is the recent directive of the Defense Department containing new regulations which modify and consolidate earlier directives under the "Doctor Draft Law" (Public Law 779, 81st Congress). Professional standards of special registrants (medical) are more clearly defined. To be professionally acceptable, a special registrant must be (1) a graduate of an approved medical school or of a foreign medical school whose graduates are recommended for consideration by the Council on Medical Education and Hospitals of the American Medical Association; (2) a graduate of any other medical school who has an M.D. degree after completing a four year medical course providing he has had 12 months of approved intern or residency training or is a diplomate of an American specialty board and is licensed to practice medicine in any state or territory of the United States, or is a diplomate of the National Board of Examiners.[1]

The law itself requires the appointment, reappointment, or promotion to a grade "commensurate with professional education, experience or ability." The assignment of rank will be based upon the number of years spent in appropriate professional activities subsequent to medical school graduation and prior to date of appointment. The directive states, however, that promotions must be given "at the earliest practicable date." As in the past, men who have less than four years' professional experience since graduation are entitled to a first lieutenant's commission; those who have less than 10 years, captain; less than 18, major; and 18 or more, lieutenant colonel. Navy grades are comparable. For reserve officers not on active duty, there will be no change in grade; the regulations provide, however, that the higher grade must be given them if they are called back for service.

Physicians registered under the regular draft as well as the doctor draft may now accept a commission and await their call. Formerly, these men could choose between taking a reserve commission and volunteering for immediate active duty or run the risk of being inducted as privates through regular draft channels. The fact that the services have no immediate need for more physicians accounts in part for this change. The new regulations provide that medical officers who joined National Guard or Air National Guard units after June 25, 1950 may be called on an individual basis before their unit is called. This policy has been in effect since last July.

Although the wording differs somewhat regarding physical standards for physicians, the basic principle remains the same. The directive declares: "All physicians . . . are considered to be potentially acceptable for military service provided they can reasonably be expected to be productive in the Armed Forces. . . . No person with limited physicial capabilities will be assigned by the military departments to duties which are beyond the limitations imposed by their physical capabilities."[2]

1. AMA News Notes 2:1 (Nov.) 1953.
2. J. A. M. A. 153:11A (Oct. 24) 1953.

Four Medical Bills Rated Important at Next Session of Congress

A representative group of Senators and Representatives regard four issues of significance to the medical profession among the more important questions to come before the next session of the 83rd Congress. Divided about evenly between the two partes, 186 Representatives and 39 Senators participated in a poll to sound out the lawmakers' sentiment, conducted by the Congressional Quarterly, a factual news service devoted to reporting and analyzing Capitol Hill trends.

Forty subjects were submitted, with the request that they be graded in order of importance. First among the four medical issues was social security, which won sixth place in the poll. The question is whether or not 10.5 million persons, including physicians, shall be brought under social security coverage. This legislation was requested by President Eisenhower in the closing days of the last session of the Congress and will be pressed by the administration at the forthcoming session.

Tax legislation was rated ninth in importance. While the House Ways and Means Committee is working out a complete revamping of tax laws, the Jenkins-Keogh plan is of paramount importance to physicians. It would permit physicians and other self-employed persons to defer income tax payments on a portion of their income which would be put into restricted annuity programs, a privilege now accorded corporation employees. The American Medical Association strongly supports this plan.

In thirteenth place was aid to schools and hospitals. Couched in broad terms, this measure presumably would include aid to hospitals and clinics under a national health plan as well as support for the Hill-Burton hospital construction program.

Regarded as fifteenth in importance was veterans' services. Included would be the question of whether the Congress should expand or restrict care of nonservice-connected cases. The American Medical Association proposes that care be restricted to (1) service-connected cases, and (2) certain long term nonservice cases when the veteran himself cannot pay. In all other nonservice-connected cases, the responsibility would rest on the individual himself or the community.

With the Congress back in session this month, both the accuracy of this poll and the ultimate disposition of the proposed legislation will be of particular interest to physicians.

The Editor Invites Your Contributions on Data of Notable Interest

Systems of Government Delightfully Defined

Public relations conferences have a way of running the gamut from vitriolic excoriations in politics to today's changing connotation of words. One speaker at the recent Public Relations Institute of the American Medical Association defined systems of government in delightfully novel terms. The enlightening outburst went something like this:

Idealism. If you have two cows, you milk them both, use all the milk you need, and have enough left for your neighbors.

Socialism. If you have two cows, you keep one and give the other to the man next door.

Communism. If you have two cows, you give both to the government; then the government gives you back a little milk.

Imperialism. If you have two cows, you steal somebody's bull.

Capitalism. If you have two cows, you sell one and buy a bull.

New Dealism. If you have two cows, the government shoots one; you milk the other, then dump half the milk down the sink.

Nazism. If you have two cows, the government shoots you and takes the cows.

Realism. If you have two cows, they're both dry.

Exploitation of Heartbreak Cases Damaging to American Medicine

More and more frequently lately, the public is being confronted with instances of exploitation of heartbreak cases by television, radio and newspapers. The subject of medically needy cases, especially those tearfully portrayed before television audiences, received thorough discussion recently during a public relations conference sponsored by the Medical Society of the State of New York.

The "heartbreak case" was described as one in which an appeal is made for funds through television, radio or press to pay for extensive medical care or an operation, the cost of which is overwhelming to the person involved. Investigation of many heartbreak cases, it was pointed out, has shown that the patients did not consult with hospital authorities or ask their county medical societies what could be done. They preferred instead "to glamorize their plight." The consensus

among the conference members was that exploitation under these unfortunate circumstances must stop.

"The patient must be informed," Dr. James D. Tyner of Newark told the conference, "that regardless of ability to pay he need only ask to receive the services of a doctor or hospital care. In these cases, the county medical society, state welfare department and voluntary health organizations are ready to help every deserving person.

"How many people know that doctors in wards and clinics of hospitals throughout America give their services daily without charge? The average doctor spends 12 per cent of his working hours doing charity work. The dollar value of the time given to charity patients by the average M.D. is more than $3,000 annually and his donation of time from 1947 to 1951 increased 15 per cent."

After pointing out that the social welfare laws of New York State make it mandatory upon the welfare district to provide necessary medical and hospital care for those persons unable to secure it, Dr. Tyner continued: "Physicians are already giving service to thousands of potential heartbreak cases in their everyday duties. We must let the people know this fact, and try to prevent the few cases that are dramatized from damaging the good name of American medicine."

The medical profession, not only of New York State but of every state, needs to put aside its traditional modesty and expose this sham. The public should be fully apprised of the profession's deep concern with the problem of adequate care for the medically indigent or those confronted with overwhelming medical expense. It should know what is being done daily the country over by physicians to cope with this problem.

How Long Can It Last?

Proverbially, figures do not lie. They do, however, raise grave questions at times and portend ill for the future.

In the 20 years just ended, for example, the government spent more than $775,000,000,000 and ran up a net deficit of more than $239,000,000,000. What happens next when your government spends in two decades almost half again as much as it was able to collect, despite steadily increasing taxes?

Back in 1933 the national debt was a fraction less than $180 for each American. Today the figure exceeds $2,000. A typical family of 1933 with a $4,000 annual income paid $44 in federal income taxes; now the sum approximates $500. Incredible as it may or may not seem with March 15 once more just around the corner, tax collections in the last fiscal year were 2,100 per cent greater than in 1933.[1]

Such thought-provoking figures on government spending deserve careful perusal. Certainly they raise questions grave indeed, chief among them: How long can any nation stand such a trend without going bankrupt?

1. Secretary's Letter, No. 271, American Medical Association, citing "It Cost You 775 Thousand Million Dollars" by Paul L. Martin, chief of the Washington Bureau of the Gannett newspapers, in the October issue of the American Mercury, pages 5 to 10.

"More 'U' In CommUnity" Rural Health Conference Theme

"Let's Put More 'U' In CommUnity" is to be the theme of the ninth National Conference on Rural Health, scheduled for March 4 to 6, 1954 at the Baker Hotel in Dallas, Texas. Leaders in the fields of medicine, agriculture, education and public health will be in attendance, and the principal subjects for discussion will be problems of nutrition and costs of medical care and methods of prepayment. A major feature of the program will be success stories by members of the audience. This meeting is sponsored by the Council on Rural Health of the American Medical Association, and will stress individual participation in community affairs.

As has been the custom for several years, a preconference session for physicians only will be held on Thursday morning, March 4. This session will deal with problems confronting physicians who are members of state rural health committees or committees handling rural health problems. Major subjects for consideration are physician participation at the grass roots and problems pertaining to health insurance matters.

This call for all-out community teamwork is just as applicable to urban as to rural health. There is continuing need everywhere for more 'U' in commUnity. More than ever today, the good citizen is part and parcel of his community, rendering it real service. In health matters particularly and in general community welfare, the physician everywhere has a golden opportunity through personal service to put more 'U,' and perchance also more 'Unity,' into his commUnity.

New Top Medical Official in Defense Department

Dr. Frank Brown Berry has been chosen to succeed Dr. Melvin A. Casberg shortly after the first of the year in the office of Assistant Secretary of Defense for health and medical affairs. Dr. Berry is a New York surgeon with military service in both World Wars. Professor of clinical surgery at Columbia University College of Physicians and Surgeons, Dr. Berry holds the rank of brigadier general, retired. In World War II he was on active duty for four years, from 1942 to 1946, and headed the 9th Evacuation Hospital in various parts of Europe. He has served as special consultant to the Army Surgeon General, for whom he made a special trip to Korea in 1951.

When he assumes office, Dr. Berry becomes the highest ranking medical official in the Defense Department. He is responsible for the operation and coordination of the Army, Navy and Air Force medical departments. He has direct contact with the three surgeons general. When the Secretary has approved his recommendations, they are transmitted to the three medical departments.

Dr. Casberg will return to the private practice of surgery in California.

Mental Health Milestone

A Conference on Mental Health, held in Washington last October, was a history-making event which augurs well for progress in coping with America's No. 1 health problem — mental illness. Sponsors of the conference were two of the oldest national medical organizations in North America, the American Medical Association, founded in 1847, and the American Psychiatric Association, founded in 1844 when 13 superintendents of hospitals for the insane met in Philadelphia.

The conference was of particular importance in that it marked the first time representatives of every medical and lay organization interested in the battle against mental illness had had an opportunity to face one another across the conference table and enter into friendly discussion of this major medical problem in a helpful atmosphere. More than 50 lay and medical organizations participated.

While most aspects of the mental health problem were discussed, the four major topics on which the discussion centered were: the educational process in training mental health workers, research, treatment, and prevention. Dr. Walter B. Martin, President-Elect of the American Medical Association, expressed the main objective of the two sponsoring organizations when he said: "There is a growing confidence in psychiatry and a mounting conviction that its principles need to be reintroduced into all phases of medical practice, to rehumanize medicine and, in this sense, return to medicine as a healing art. . . . This occasion may well mark the remarriage of partners, who should never have been divorced in the first place."

The conference proved highly successful, and it was left to the planning committee to decide whether it should be held annually.

Evolution of Osteopathy

Evolution Again. Somewhere in this issue of the Columbus Academy is an article which abstracts the report of the Committee for the Study of the Relations Between Osteopathy and Medicine, in which a Committee of able men led by John W. Cline, a former President of the American Medical Association, has devoted considerable time and study to the changes that have occurred in the field of osteopathy.

Osteopathy has undergone a process of evolution that has brought it to the point of such similarity to medicine that no marked fundamental differences exist between the two. The entrance requirements for schools of osteopathy and schools of medicine are identical. The curriculums have the same contents, except for the inclusion of the osteopathic theory, diagnosis and treatment. The period of instruction in both instances is four years. The clock hours devoted to teaching basic sciences, medicine and surgery are as great in schools of osteopathy as in schools of medicine. The level of instruction in basic sciences is demonstrated by the record of osteopathic candidates in examinations in these subjects. To illustrate the improvement in the caliber of instruction, it is interesting to note that in 1942, when 85.6% of the medical candidates passed basic science examinations, that only 55.4% of osteopathic candidates passed it. However, in 1952, 88% of the medical, and 84.5% of the osteopathic candidates passed the basic science examination. This is indeed, a remarkable improvement in caliber of instruction.

SOME TOP PERFORMERS. It is generally recognized by the Committee that the quality of instruction in medical schools is definitely superior to that of osteopathic schools. However, it reports that an acceptable, but unnamed source states that the performance of a considerable number of students graduated from the best osteopathic schools is now superior to that of some of the students graduated from some of our medical schools.

One of the most admirable features of the report of this Committee is the restatement of one of the major objectives and responsibilities of the American Medical Association, which is an avowed aim to improve the health and medical care of the American people. This report will demonstrate to the American people as a whole, and particularly to physicians, that this objective is not mere lip service or the proclaiming of high-sounding ideals. It gives tangible evidence that we are actively attempting to fulfill this objective.

There is no doubt that many physicians will have what they consider valid objections to the findings of the Committee. However, the delegation of action to the state boards, and the deliberate plan recommended by the Committee seem to me to be overwhelming evidence of the sound deliberation that is demonstrated throughout the report. Just as with time the distinction between homeopathy and allopathic medicine diminished to the point where now many of our modern medical students and physicians can no longer define the differences, so in time may the differences in osteopathy and medicine diminish; all to the ultimate benefit to the health of the American people. This is indeed, a process of educational evolution.

— G.J.H.

Reprinted from the Columbus (Ohio) Academy in the Bulletin of the Los Angeles County Medical Association, Los Angeles, Calif., Nov. 5, 1953.

Press-Radio-Television Conference

Under the sponsorship of the Florida Medical Association, a Code of Cooperation between Physicians-Hospitals and the Press-Radio-Television was drafted at a conference in Jacksonville on Nov. 14, 1953. The code is to be used as a guide for county medical societies to follow when developing a workable policy on medical news in their communities.

Dr. Edward Jelks, Public Relations Liaison to the Association's Board of Governors, presided. Dr. Frederick K. Herpel, president; Dr. Samuel M. Day, secretary-treasurer; Dr. John D. Milton, Board of Governors, and Dr. Henry L. Smith Jr., member of the Public Relations Committee, also represented the Association. Mrs. Richard F. Stover, president-elect, spoke for the Association's Woman's Auxiliary.

Attending from the American Medical Association was Mr. John Bach, director of press relations, who presented a resume of successful codes being used in other states.

Mr. Jack Monahan, executive secretary, was present for the Florida Hospital Association. Mr. Robert Dow Jr., president of the Associated Press Association of Florida, represented the daily newspapers' managing editors, and Mr. Eugene L. Matthews, executive committee, Florida Press Association, spoke on behalf of the weekly newspapers. The Florida Association of Broadcasters was represented by Mr. Kenneth Small for radio and Mr. Bill Grove for television.

Speaking at the opening of the meeting, Dr. Herpel stated that he believes it a very encouraging sign that physicians and the press are alert to the importance of giving accurate medical information to the public. Therefore, the two groups should meet together so that physicians may learn the type of cooperation the press needs and the press the authoritative medical information only physicians are qualified to give.

Medical Officers Returned

Dr. George D. Hopkins II, who entered military service on Sept. 7, 1951, was released from active duty on Sept. 3, 1953 with the rank of captain (U.S. Army). His address is 104 Crescent Bldg., Fort Myers.

The Editor Invites Your Contributions on

Data of Notable Interest

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Ayer, Orion T. (Col.), St. Petersburg
Collins, Cecil C. Jr., Jacksonville
Edwards, Ray O. Jr., Jacksonville
Ettinger, Charles D., South Miami
Fisher, John J., Jacksonville
Furman, Irvine K., Jacksonville
Hammond, Daniel O., Miami
Huth, Edgar W., Anna Maria
Johnson, Whedon, Sarasota
Kummer, William M., Lakeland
Messer, Addison L., St. Petersburg
Northup, Edwin C., St. Petersburg
Rosof, Jacob A., Hollywood
Rothermel, Robert E., St. Petersburg
Smith, Vernon L., Pensacola
Spindler, James F., Dunedin

BIRTHS AND DEATHS

Births

Dr. and Mrs. Solomon B. Goldman of Miami Beach announce the birth of a son, Howard Scott, on Oct. 10, 1953.

Dr. and Mrs. Chester Cassel of Miami announce the birth of a daughter, Laurie Gail, on Oct. 18, 1953.

Dr. and Mrs. Julian A. Rickles of Miami announce the birth of a son, Richard Samuel, on Oct. 20, 1953.

Dr. and Mrs. Thomas L. Roberts Jr. of Fort Lauderdale announce the birth of a daughter, Kathy.

Dr. and Mrs. George P. Beach of Daytona Beach announce the birth of a daughter.

Dr. and Mrs. Joseph C. Flynn of Daytona Beach announce the birth of a daughter.

Dr. and Mrs. Joel Mendelson of Daytona Beach announce the birth of a daughter.

Deaths — Members

Meister, A. George, Fayetteville, N. C. ..... Nov. 17, 1953
Broadbent, Oliver P., Jacksonville ..... Nov. 22, 1953

Deaths — Other Doctors

Rankin, Howard P., Cairo, Ga. ..... April 16, 1946
Cranford, J. Frank, Gastonia, N. C. ..... Oct. 10, 1946
Brantley, John Q., Atlanta, Ga. ..... Nov. 21, 1947
Elliott, Loren F., Albuquerque, N. Mex. ..... Dec. 12, 1949
Gammage, Frederick V., Grundy, Va. ..... Aug. 21, 1950
Williams, Jack K., Salisbury, Md. ..... July 27, 1953
Hatchett, William C., Hollywood ..... Oct. 26, 1953

STATE NEWS ITEMS

Mr. John Bach, director of press relations for the American Medical Association, was in Florida Nov. 13-19, 1953, for two scheduled addresses and a series of meetings with officers of various county medical societies.

Mr. Bach was the principal speaker on November 14 in Jacksonville at a meeting sponsored by the Florida Medical Association for the purpose of drafting a Code of Cooperation between physicians-hospitals and the press-radio-television. Following this meeting he consulted with the staff of the Association in the executive offices.

On November 17, he met with Drs. Morris B. Seltzer, president, and C. Robert DeArmas, chairman of the Committee on Public Relations, of the Volusia County Medical Society in Daytona Beach. In Orlando the following day, Mr. Bach discussed press relations with the Committee on Public Relations of the Orange County Medical Society and was principal speaker at a dinner meeting of the Society to which representatives of the press, radio and television were invited. Also present were officers of surrounding county medical societies.

While in Florida, Mr. Bach discussed press relations with Drs. Frederick K. Herpel, Association president, Duncan T. McEwan, president-elect, and Edward Jelks, liaison for public relations on the Board of Governors.

Dr. Louis M. Orr of Orlando, Chairman of the A.M.A. Committee on Federal Medical Services, presided at an A.M.A. sponsored regional conference in Atlanta on November 8. Non-service-connected disabilities in medical care for veterans was the topic discussed at the meeting.

Members of the Florida Medical Association in attendance were President Frederick K. Herpel, West Palm Beach; Dr. Frederick H. Bowen, Chairman of the Sub-Committee to the Board of Governors on Veterans Care, and Dr. George M. Stubbs, member of the Sub-Committee, both of Jacksonville; Dr. Reuben B. Chrisman Jr. of Miami, delegate to the A.M.A.; and Drs. James L. Bradley, Fort Myers; Norval M. Marr and Alvin L. Mills, St. Petersburg. Harold Parham represented the executive office.

Dr. Bernard L. N. Morgan of Jacksonville attended the meeting of the British Association of Plastic Surgeons in England in September. Dr. Morgan has been elected as a member of the Association.

Dr. Harold Rand of Miami has returned to his practice after attending a seminar on cardiovascular diseases in New York City under the auspices of the American College of Physicians.

Dr. DeWitt C. Daughtry of Miami, president of the South Florida Alumni Chapter of Alpha Kappa Kappa medical fraternity, took part in the installation of the first chapter of the fraternity to be installed in Florida. The new chapter was installed at the University of Miami.

The Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology will be held at the Sans Souci Hotel in Miami Beach on Wednesday, Jan. 20, 1954. The guest speakers for the afternoon scientific session will be Dr. Howard P. House of Los Angeles and Dr. William C. Owens of Baltimore. At 8 p.m. there will be the usual informal banquet. This meeting is held each year concurrently with the annual Midwinter Seminar of the Graduate School of Medicine of the University of Florida. Physicians attending the Seminar are invited to attend the Convention, and all Seminar registrants and their wives may attend the banquet.

For the eighth consecutive year the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will convene in Miami Beach on Monday, Jan. 18, 1954, and will continue throughout the week. A faculty of wide renown will present lectures in Ophthalmology on January 18, 19 and 20 and in Otolaryngology on January 21, 22 and 23.

Dr. Sherman B. Forbes of Tampa made a flying trip to San Francisco recently to observe goniotomy procedures at the invitation of Dr. Otto Barkan.

Dr. Rex B. Perkins of Winston-Salem, N. C. entered medical service with the U. S. Army on Aug. 1, 1952. He holds the rank of captain.

Dr. George F. Schmitt Jr. of Miami spoke at recent meetings of the North Shore Kiwanis Club and the North Shore Lions' Club.

Dr. Frank G. Slaughter of Jacksonville spoke at the District 6 meeting of Blue Cross - Blue Shield at The Inn, Ponte Vedra, Thursday, November 19 on "Destiny and Disease." District 6 includes the states of Louisiana, Mississippi, Alabama, Georgia, Florida and Tennessee.

Drs. Bernard L. N. Morgan, Gordon F. King and Francis A. Copp of Jacksonville attended a postgraduate course at the University of Illinois Cleft Palate Center recently. Their attendance was sponsored by the Crippled Children's Commission.

Dr. Walter C. Payne of Pensacola spoke to the Florida A and M University Hospital Medical Staff on "Professional Relationships in Modern Hospitals" in Tallahassee on November 17. The meeting was attended by the joint staffs of the Forsyth Memorial, W. T. Edwards and Tallahassee Memorial Hospitals.

Dr. Ashbel C. Williams of Jacksonville was principal speaker at the first in a series of area meetings on cancer education for women, sponsored by the Duval County unit of the American Cancer Society. The meeting was held at the Southside Grammar School on November 16.

Mr. Harry E. Simmons, executive director of the Florida Council for the Blind, has asked The Journal to help dispel false rumors that cellophane strips from cigarette packages can be used to obtain a Seeing Eye Dog for a blind person. Simmons said that this information is a rumor only, and for some reason it is revived from time to time. The Seeing Eye, Inc., is an organization in Morristown, N. J., which trains guide dogs for blind people, and cellophane strips have nothing to do with the furnishing of dogs and other considerations.

It was stated that any blind person between the ages of 16 and 55 who wants a Seeing Eye Dog should communicate directly with the Seeing Eye, Morristown, N. J. His eligibility will be established promptly and information given on procedure.

Dr. Graham W. King Jr. of Delray Beach took part in a question and answer session at a meeting of the Palm Beach County Heart Association in November.

Dr. John R. Butter of St. Petersburg spoke at a meeting of the Clearwater Rotary Club in November.

Dr. Michael A. DiCosola of Sarasota addressed Civil Defense first aid classes on November 24 on emergency handling of bone fractures.

Dr. Bernard M. Barrett of Pensacola was honored by the Civitan Club of that city at a recent meeting. He was given a standing vote of thanks and awarded a certificate for his efforts and cooperation in the Civitan tonsillectomy program.

Dr. Herschel G. Cole of Tampa, president of the Florida Orthopedic Society, presided over the mid-year meeting of the Society in Tampa, November 7 and 8.

Dr. George L. Rand of Miami Beach has been promoted to the rank of colonel in the Medical Corps of the U. S. Army Reserve.

Dr. John H. Mitchell of Jacksonville has been re-elected vice president of the Baptist Home for Children of North Florida.

Dr. Karl B. Hanson of Jacksonville spoke on "Heart Disease and Vocational Rehabilitation" before the National Vocational Rehabilitation Association in Miami in October.

Dr. William E. Kendall of St. Petersburg attended the scientific session of the Association of Military Surgeons in Washington in November.

Dr. Duncan T. McEwan of Orlando spoke at the annual meeting of the officers and committee chairmen of the Woman's Auxiliary to the Florida Medical Association in Orlando in November.

Drs. Francis D. Pierce, Thomas L. Roberts Jr. and Scottie J. Wilson of Fort Lauderdale appeared on a half-hour public service seminar on WFTL-TV in conjunction with National Diabetes Week, Nov. 15-21, 1953.

Dr. Roger E. Phillips of Orlando was principal speaker at the annual banquet of Division 2 of the Licensed Practical Nurses Association of Florida on November 17.

Dr. Raney A. Oven of Tallahassee spoke at the Conference of Florida Children's Commission meeting in St. Petersburg.

Dr. James L. Borland of Jacksonville was guest speaker at the meeting in St. Luke's Hospital of the Northeast Chapter of the Florida Society of Medical Technologists on November 10.

Dr. Mason Romaine III of Jacksonville attended several clinics at Grady Hospital in Atlanta in October.

Dr. Nelson A. Murray of Jacksonville attended the annual sessions of the College of American Pathologists and the American Society of Clinical Pathologists in Chicago in October.

Dr. Richard G. Skinner Jr. of Jacksonville attended the annual Conference on Services to Handicapped Children in St. Petersburg in November.

Dr. Hugh A. Carithers of Jacksonville attended the annual meeting of the Florida Children's Commission in St. Petersburg in November.

Dr. Frank G. Slaughter of Jacksonville spoke on "Music and Medicine in History" at the November meeting of the Music Teachers' Association of Jacksonville.

Drs. Sullivan G. Bedell and Nathan Weil Jr. of Jacksonville took part in a conference on retarded children sponsored by the North Florida Association for Retarded Children in November.

Dr. Ralph S. Sappenfield of Miami was elected vice speaker of the American Association of Anesthesiologists at the annual meeting in Seattle in October.

Dr. George W. Robertson III of Miami has returned to his practice following a three months teaching Fellowship at the Tulane University School of Medicine in New Orleans.

Drs. W. Tracy Haverfield and Parke G. Smith, both of Miami, gave a paper on "Arterial Visualization of the Brain and Kidney" at the Fort Clayton General Hospital in Panama in October.

Dr. Robert G. Nelson of Tampa has taken office as president of the South Atlantic Association for 1954.

Dr. Paul W. Hughes of Fort Lauderdale spoke at a luncheon meeting of the Sinawik Club in Hollywood in November.

Dr. James M. San of Tampa took part in a panel discussion on the feeding habits of children at the Guidance Center of Hillsborough County in November.

Dr. Roger E. Phillips of Orlando spoke on the state facilities for prevention and cure of mental illness at a meeting of the Central Florida Mental Health Association in November.

Dr. Charles W. Duval of Pensacola was the guest of honor on November 19 at a party given by local doctors at the Pensacola Country Club. Dr. Duval is retiring as pathologist at the Sacred Heart Hospital.

Dr. Wm. E. Van Landingham of West Palm Beach spoke on "County Welfare of the Palm Beaches" at a meeting of the Property Owners Managers Association of the Palm Beaches on November 19.

Dr. Efton J. Thomas of Miami Beach attended the annual meeting of the Interstate Postgraduate Assembly in Chicago, November 2-5.

Dr. Turner Z. Cason of Jacksonville spoke on "Cardiovascular Disease: Causes and Treatment" at the weekly luncheon meeting of the Jacksonville Junior Chamber of Commerce on November 10.

Dr. James R. Nieder of Delray Beach spoke on cataracts at a meeting of the American Association of University Women of Delray Beach in October.

Dr. Paul Kells of Miami spoke on "Sleeping Pills — Are They Good or Bad?" before the Miami Civitan Club in November.

Dr. Jere W. Annis of Lakeland served as a member of the editorial board which collaborated in production of a "Book of Health," a medical encyclopedia compiled for public use.

The new South Dade High School building in Homestead was dedicated on November 15 to the late Dr. John B. Tower, pioneer physician of the area. Dr. Tower, who died in 1939, was a member of the Florida Medical Association.

Dr. Richard G. Skinner Jr. of Jacksonville represented the Florida Medical Association at a meeting of the Florida Campaign Committee in connection with the March of Dimes program. The meeting was held in Jacksonville on December 4.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

SURGEON: Age 39, F.A.C.S. and Board Eligible, seeking association with older surgeon, or community in need of a well trained general surgeon. Write 69-106, P. O. Box 1018, Jacksonville, Fla.

TO RENT: Modern office building, x-ray and all diagnostic equipment, splendid practice established since 1916. All communications welcomed and confidential; available December 15th; retiring for reason of ill health. G. H. Brantley, M.D., Box 1151, Lake Worth, Fla.

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COMPONENT SOCIETY NOTES

Bay

The Bay County Medical Society added a transcribed radio program to its public relations activities the latter part of November, according to announcement by Dr. William C. Roberts, Panama City, chairman of the Society's Committee on Public Relations. Cooperating with station WDLP in Panama City, the Society is presenting medicine in its relationship to the various sports. The program is being broadcast in connection with a locally produced high school show.

Broward

The Broward County Medical Association met in Hollywood on November 24. Heretofore all meetings have been held in Fort Lauderdale, but under the new system which has just been put into effect, frequent sessions will be held in Hollywood.

Dade

Senator George Smathers was guest speaker at the regular monthly meeting of the Dade County Medical Association on December 1.

(Continued on page 502)

The Problem of Nausea and Vomiting:

ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats[1] outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

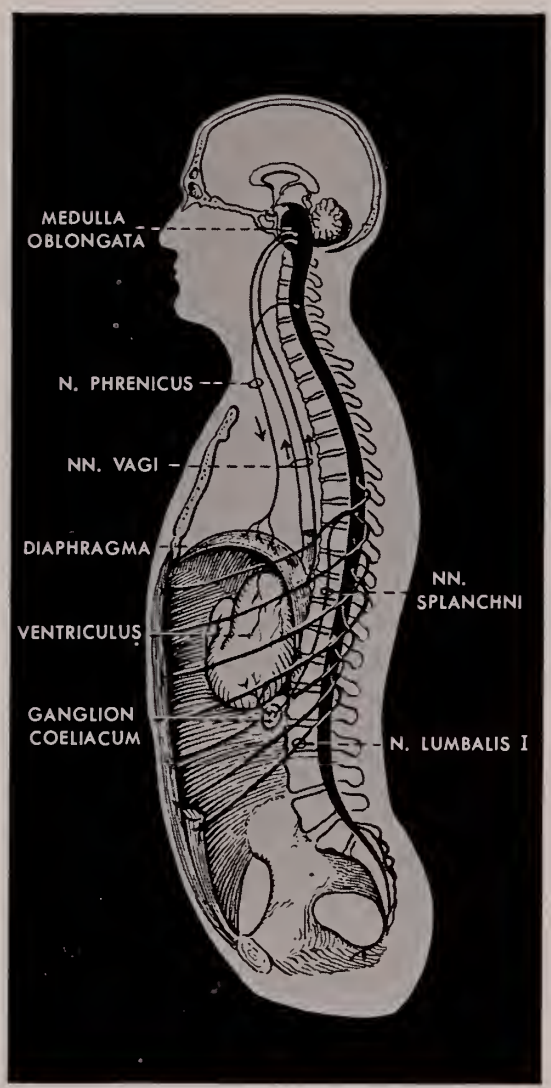
The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."[2]

Dramamine Liquid is particularly useful for children.

Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akinetic Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey *50*:53 (Feb.) 1953.
2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953. Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus→ nodose ganglion→ solitary tract→ spinal cord→ cervical, thoracic and lumbar nerves to diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature. (After Krieg, W. J. S.: Functional Neuroanatomy, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)*

SEARLE *Research in the Service of Medicine*

(Continued from page 500)

Duval

The regular meeting of the Duval County Medical Society was held on December 1.

The Centennial Anniversary Banquet of the Society was held on December 16 at 7:00 p.m. at the Ballroom of the George Washington Hotel in Jacksonville. Speaker was U. S. Senator George Smathers. More details of the Centennial Celebration may be found on page 337 of the November 1953 Journal.

Hillsborough

The regular monthly meeting of the Hillsborough County Medical Association was held on December 1 at the Floridan Hotel in Tampa.

Lake

Officers of the Lake County Medical Society were among the guests of the Orange County Medical Society at a meeting in Orlando on November 18. At this time, Mr. John Bach of Chicago, A.M.A. director of press relations, gave a talk on public relations.

At the regular November meeting of the Society, Dr. Lincoln P. Elam Jr. of Wildwood was a guest.

Monroe

At the regular November meeting of the Monroe County Medical Society, Dr. Ramsey MacCordy, anesthesiologist at the U. S. Naval Hospital in Key West, lectured on recent advances and newer technics in anesthesia. A roundtable discussion followed the talk.

Orange

Mr. John Bach, director of press relations of the A.M.A., was principal speaker at a dinner meeting of the Orange County Medical Society on November 18. Representatives of the press, radio and television were invited as well as officers of the surrounding county medical societies.

Pinellas

The regular meeting of the Pinellas County Medical Society was held on December 7. Speaker of the evening was the Honorable Courtney Campbell, U. S. Representative from that district.

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OBITUARIES

Thaddeus Hall Green

Dr. Thaddeus Hall Green of St. Petersburg died suddenly at his home on Sept. 16, 1953, from a heart ailment. He was 62 years of age.

A Floridian, Dr. Green was born in Dellwood on Sept. 25, 1890. He received his medical training at Emory University School of Medicine, where he was graduated in 1914. He was licensed in Florida that same year and located in St. Peterburg in 1916.

For 35 years Dr. Green engaged in the general practice of medicine in St. Petersburg. He was a member of the medical staff of Mound Park Hospital. He held membership in the Four Square Church and was a Mason.

Since 1916 Dr. Green had been a member of the Pinellas County Medical Society, and also of the Florida Medical Association, in which he had been a life member for three years. He was also a member of the American Medical Association.

Survivors include the widow, Mrs. Ruth Green of St. Petersburg; one daughter, Mrs. Betty Nelson of Miami; a stepson, Harold Massey of St. Petersburg; two brothers, David Green of St. Petersburg and Corey Green of Bascom; and two sisters, Mrs. Priscilla Kirkland and Mrs. Frank Conrad, both of Tallahassee.

Arthur Patchen MacVeany

Dr. Arthur Patchen MacVeany of Miami died unexpectedly at his home on Sept. 22, 1953. He was 57 years of age.

A graduate of Columbia University College of Physicians and Surgeons in 1927, Dr. MacVeany spent the first 10 years of his professional career in general practice in New York City. In 1937 he limited his practice to obstetrics and gynecology.

In June 1944 he came to Florida from Forest Hills, Long Island, New York, and engaged in the practice of his specialty in Miami. He soon became one of that city's outstanding obstetricians and served on the staffs of the leading hospitals. His untiring efforts in behalf of Mercy Hospital were a major factor in its building and maintenance. Locally, he was a member of SS. Peter and

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From where I sit
by Joe Marsh

A Case of "Moostaken" Identity

Slim Smith never had a chance to use his moose call until a trip north this year. Visited him yesterday to see what he'd bagged.

"First day out," he told me, "I picked up a trail. I sounded the call and waited. Then I heard a moose call. Sure enough, something came crashing through the brush. But it was another guy with his moose call. Boy, did I get my finger off the trigger in a hurry!"

My last day there I picked up another trail. And this time I got me a real moose. But you can bet your bottom dollar I took a good look before I did any shooting!"

From where I sit, we could all learn a little from Slim's experience. Most of us are guilty sometime or other of being too quick on the trigger. Like the fellow who would tell me how to practice my profession . . . or even deny me an occasional glass of beer with my dinner. I say that kind of "aim" is way off!

Joe Marsh

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Paul parish, and was a charter member of the Emerald Society, for persons of Irish ancestry.

Since 1945 Dr. MacVeany had been a member of the Dade County Medical Association and of the Florida Medical Association. He was also a member of the American Medical Association and other professional societies.

Surviving are the widow, and seven daughters, Genevieve, recently graduated from the nursing school of the Columbia Medical Center in New York City; Eileen and Sheila, student nurses at New York's Presbyterian Hospital, which is affiliated with their father's alma mater; and Marcia, Carro, Victoria and Anne Marie, all of Miami.

Alpheus Cary Koon

Dr. Alpheus Cary Koon of Lakeland died in Morrell Memorial Hospital in that city on Sept. 19, 1953. He was 63 years of age.

A native Floridian, Dr. Koon was born at Lake City on July 8, 1890. He was the son of Wiley Koon, a pioneer citizen of Suwannee County. A graduate of the old Columbia College at Lake City in 1911, he received his medical education at the Lincoln Memorial University Medical Department in Knoxville, Tenn., where he was awarded the degree of Doctor of Medicine in 1914. His hospital affiliations were St. Joseph's Hospital in Memphis, Tenn., City Hospital in St. Louis, Mo., and Morrell Memorial Hospital in Lakeland.

After receiving his license in Florida in 1917, Dr. Koon practiced in Branford for a short time before locating in Lakeland, where he engaged in the practice of medicine for 29 years. Locally, he was a member of the Presbyterian Church and of the Masonic Order.



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Dr. Koon became a member of the Polk County Medical Society in 1925, and also became affiliated with the Florida Medical Association and the American Medical Association at that time.

Surviving are the widow, Mrs. Gennie C. Koon; three sons, Alpheus C., Louis and Wiley E.; one daughter, Mrs. Eugene Allard of Salem, N. H.; three brothers, J. E. Koon of Titusville, Hugh W. Koon of St. Petersburg, and Alexander Koon of San Antonio, Texas; and one sister, Mrs. Addie Blanton of Tampa.

Helen Irene Grove Leone

Dr. Helen Irene Grove Leone of Largo died in Tallahassee on Sept. 30, 1953. Interment took place in Bayard, Iowa.

A native of Iowa, Dr. Leone was born in Guthrie Center on June 30, 1911. For a number of years she resided in St. Paul, Minn. She received her premedical training at the University of Chicago and was awarded the Bachelor of Science degree by that institution. She then attended the University of Illinois College of Medicine, where she received the degree of Doctor of Medicine in 1949. She served an internship at Grant Hospital in Chicago.

In 1950 Dr. Leone was licensed to practice medicine in Florida. In September of that year she and her husband, Dr. William A. Leone, located in Largo and since that time had engaged in the general practice of medicine there.

A member of the Pinellas County Medical Society, Dr. Leone was also a member of the Florida Medical Association and the American Medical Association. At the time of her death, she was en route to Chicago to attend an obstetric conference.

In addition to her husband, survivors include three sisters.

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BOOKS RECEIVED

The Epidemiology of Health. By Iago Galdston, M.D., Editor. Pp. 197. Price, $4. New York, Health Education Council, 1953.

This New York Academy of Medicine Book owes its title to its editor, Dr. Galdston, who describes it as "a most felicitous conjunction of terms — epidemiology and health, descriptive of precisely the very core and essence of social medicine." Although based on the Eleventh Annual Eastern States Health Education Conference, it goes far beyond the material presented at that time in crystallizing a well rounded concept of the new epidemiology of health.

In the 15 illuminating chapters, distinguished contributors demonstrate that health can be propagated. Epidemiology has long carried the connation of mass disease, but this book clearly presents the concept of the healthy mass. Moreover, it offers practical suggestions on how the objective of health in the mass can be effectively achieved. The reader finds that an epidemiology of health is already pursued in the United States Army and, to a lesser extent, in American industry. Too, the epidemiology of health has the promise of extending rapidly into the areas of individual and community health through behavior-centered health education. Here is convincing evidence that the application of this concept in clinical medicine, in public health and in health education must yield effective results.

Transactions of the American College of Cardiology. By Bruno Kisch, M.D., Editor. Pp. 252. Price, $5. New York, American College of Cardiology, 1953.

Designated Vol. II — 1952, this publication contains the transactions of the first annual meeting of the American College of Cardiology, held in New York on June 6 and 7, 1952. On that occasion the papers presented by distinguished cardiologists were on the subject of treatment of the patient with cardiac disease. Also included are the proceedings of the fall meeting held at Yale University School of Medicine on November 7 and 8, 1952. The general topic at that time was "Graphic Registrations in Cardiology."

The book contains a roster of the officers and of the more than 800 members from all over the Americas.

An Inventory of Social and Economic Research in Health. Pp. 180. Health Information Foundation, New York, 1953.

This 1953 edition of the Inventory is the second, and like the first edition appearing in 1952, is a compilation of some 250 current and recently completed research projects dealing largely with the social and economic aspects of health programs and health problems. In view of the current increasing interest in the social and economic aspects of health programs and health problems, this publication is especially useful and valuable to the ever-growing number of students in this field.

Bound together by the common thread of health problems and the social context in which they arise, the three broad areas covered are (1) disease and its correlates, (2) health economics and problems of administration, and (3) community organization and social structure. Brief abstracts of projects being conducted by national foundations, college and university research groups, governmental agencies and voluntary health organizations give the reader some indication of the major areas in which the need for objective information has led to the formulation of concrete research proposals.

The Inventory is released by the Health Information Foundation, which is sponsored by the drug, pharmaceutical, chemical and allied industries. Its president is Admiral W. H. P. Blandy, USN (Ret.), and the chairman of its Citizens Advisory Committee is The Honorable Herbert Hoover. The Foundation maintains headquarters at 420 Lexington Ave., New York 17, N. Y.

Respiratory Diseases and Allergy, New Method of Approach. By Josef S. Smul, M.D. Pp. 80. Price, $2.75. New York, Medical Library Company, 1953.

In this little book the author discusses the successful treatment of respiratory diseases and allergy by a new method. Out of his many years of experience in the field of respiratory ailments he offers simple solutions to many complex respiratory problems, stating the purposes of this book as:

(1) To show the etiology of about twenty-odd syndromes which now are described in all standard text books as separate "diseases" of the respiratory tract with doubtful or confusing causes; (2) to provide proof that all these twenty-odd separately described "diseases" are only different groups of symptoms of one disease, allergy of the respiratory tract; (3) to demonstrate a method of preventing and neutralizing the evil effects of this disease, as a result of having proven the cause and supplied the remedy; (4) to reveal the discovery of a method which obviates the customary routine of testing each patient for each allergic substance by avoiding easily eliminable offenders and, if necessary, further to treat him with just a few universal respiratory desensitizers; (5) to indicate a method which discards all local treatment, whether tampons, sprays, washing or drops, in the management of this disease, in which they are so extensively and harmfully used; and (6) to reduce confusion on the subject and relieve the physician of the burden of attempting to diagnose and treat twenty-odd imaginary diseases of the respiratory tract instead of one definite disease.

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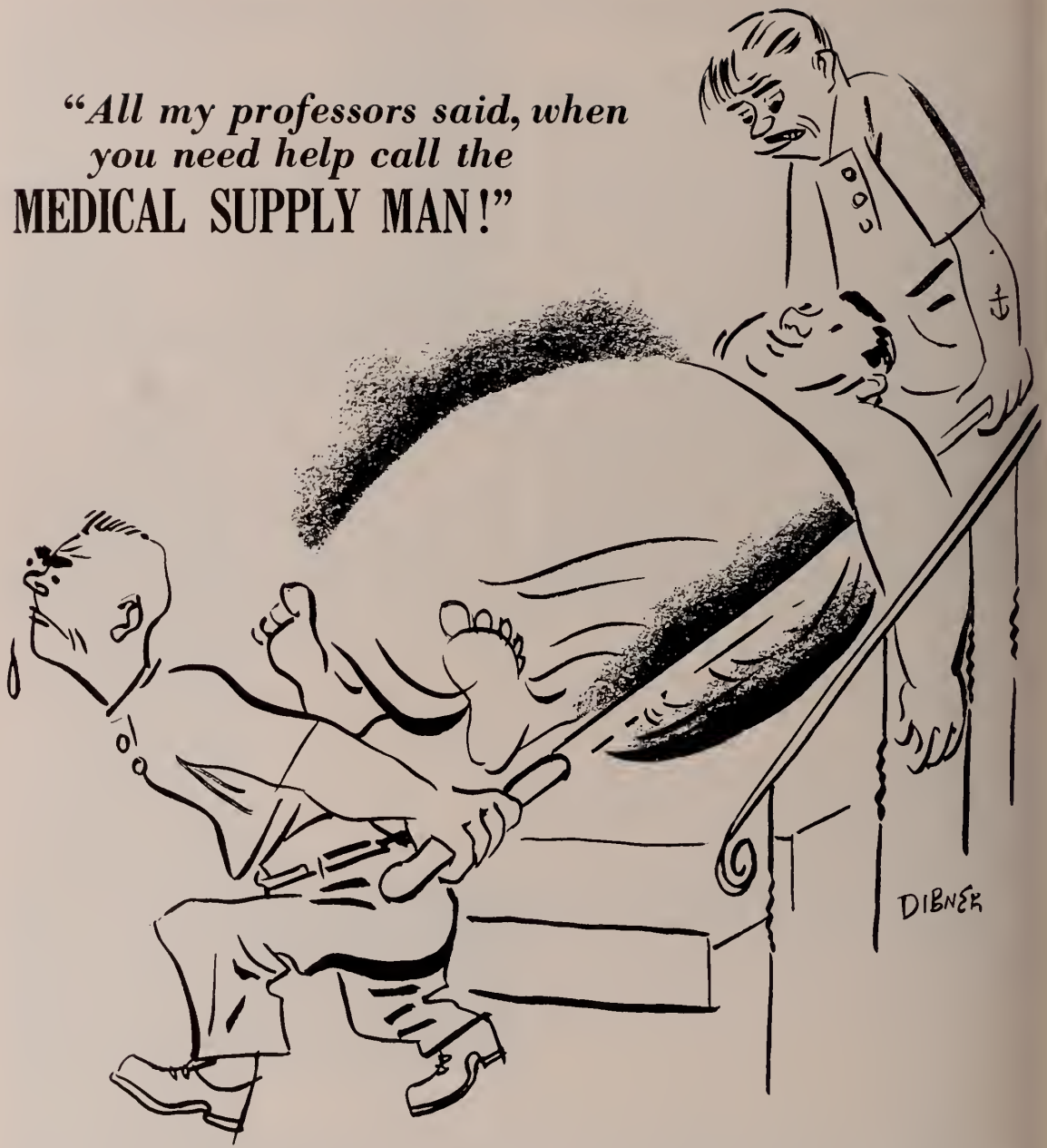
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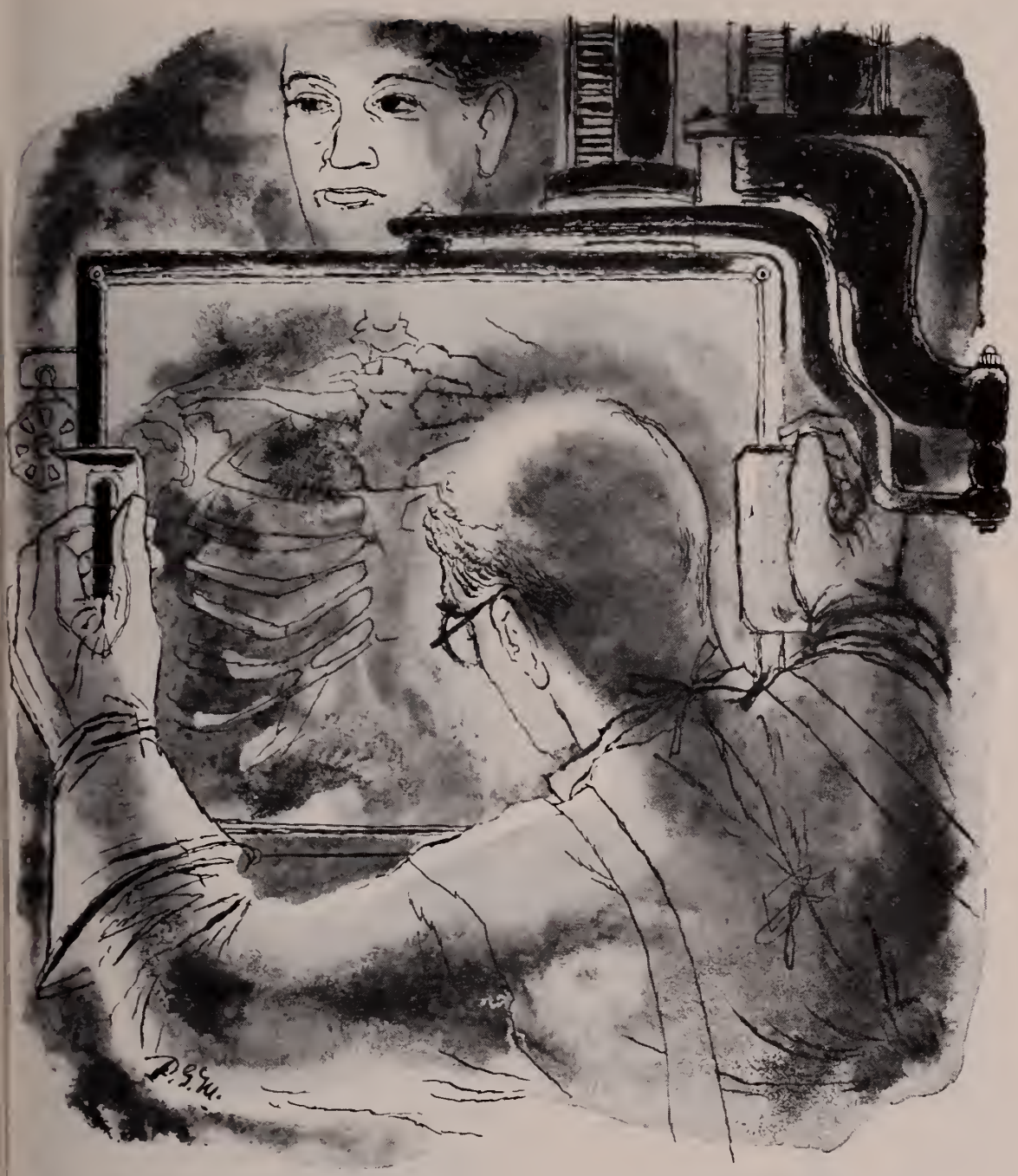
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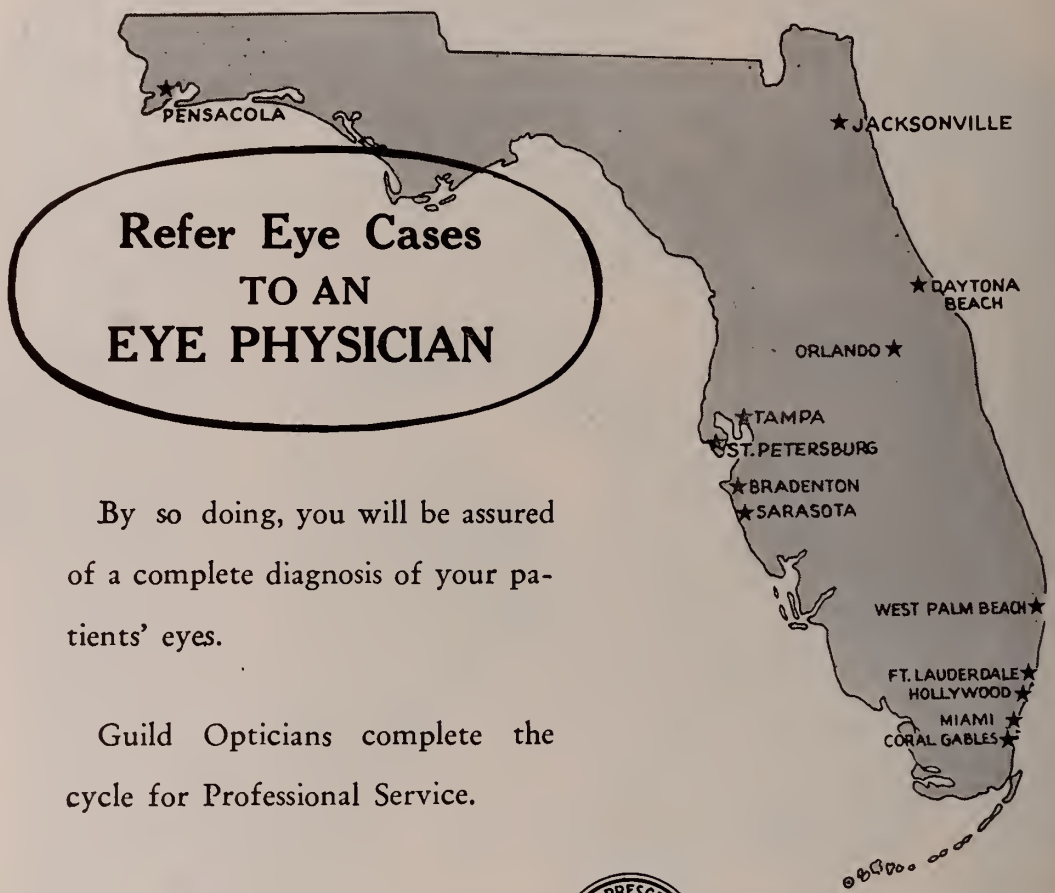
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1. Slepyan, A. H. (1952), Arch. Dermat. & Syph., 65:228, February. 2. Slinger, W. N. and Hubbard, D. M. (1951), *ibid.*, 64:41, July. 3. Sauer, G. C. (1952), J. Missouri M. A., 49:911, November.

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1. Wilhelmj, C. M.; McDonough. J., and McCarthy, H. H.: Nutrition and Blood Pressure, Am. J. Digest. Dis. *20*:117 (May) 1953.
2. Mann, G. V., and Stare, F. J.: Nutritional Needs in Illness and Disease. J.A.M.A. *142*:409 (Feb. 11) 1950.
3. McLester, J. S., and Darby, W. J.: Nutrition and Diets in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 519-524.
4. Levine, V. E.: The Blood Pressure of the Eskimo, Federation Proc. *1*:121 (Mar. 16) 1942.

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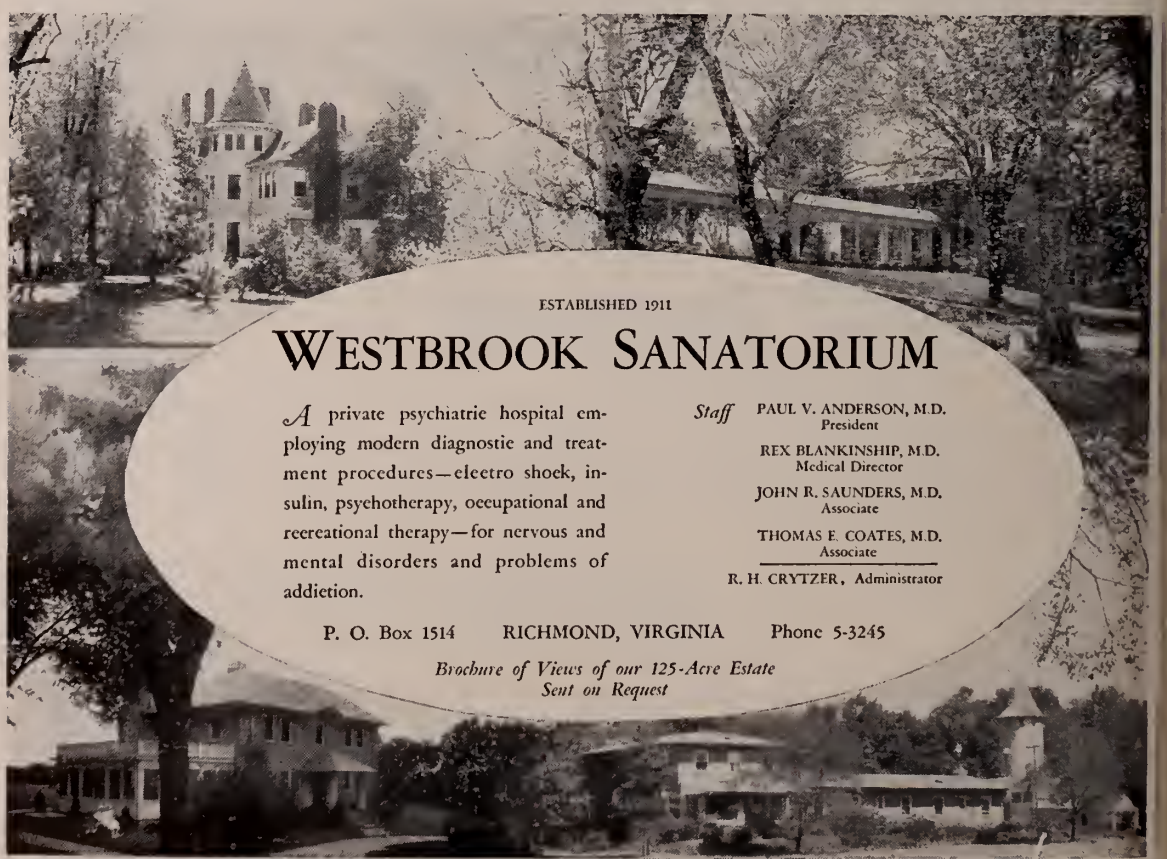
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
ledical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
ledical Districts	John D. Milton, Miami	Council Chairman	
hwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
heast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
hwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
heast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
ecialty Societies			
of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	Hollywood, Apr. 25, '54
ciety	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
ologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
l Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
ficers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
& Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
& Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
ynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
& Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
ic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	" "
sts, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	" "
Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
ic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	" "
cal Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
l Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
ience Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
oss of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
ield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, Apr. 25-28 '54
ssociation	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
l Association	Mr. T. F. Little, Daytona Beach	Mr. Tracy B. Hare, Miami	
Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Anesthetists, Fla. Assn.	Miss G E. Keyes, Daytona Beach	Mrs. Lillie Crouch, Daytona Beach	Atlanta, April '54
Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
ceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May '54
Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	St. Petersburg, Apr. 9-10, '54
losis & Health Assn.	Leffie M. Carlton Jr., Tampa	Mrs. L. C. Conant, Fort Myers	" "
's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers Jr., Cocoa	Hollywood, Apr. 25-27, '54
Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 30-Dec. 3, '54
Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
ledical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
ital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
ern Allergy Assn.	Walker L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, '54
ern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
ern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
t Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	



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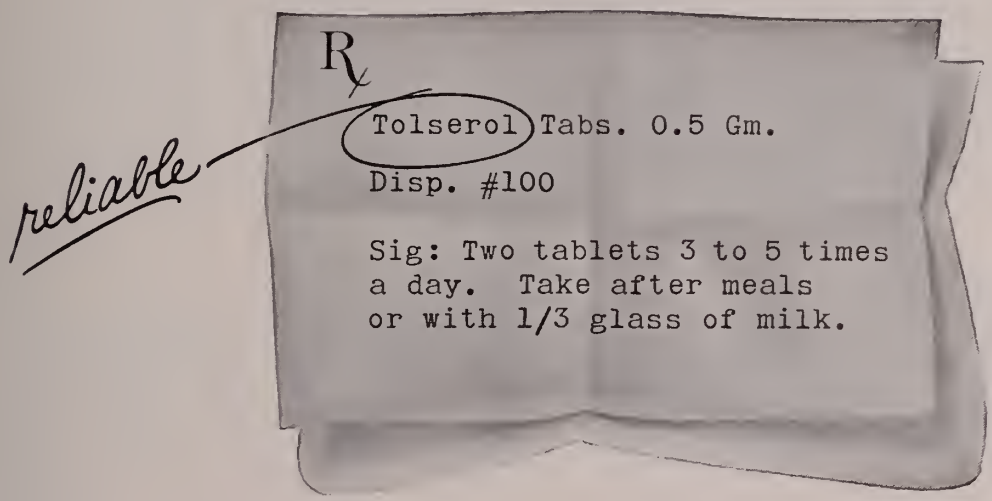
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.
**Bradford, Gilchrist, Union*			
Bay	Lemuel F. Coxe Jr., Panama City	James M. Nixon, Panama City	1st Tues.
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.
**Baker, Hamilton*			
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.
**Santa Rosa*			
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.
**Sumter*			
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison	
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.
**Osceola*			
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.
Taylor	George H. Warren, Perry	Mark E. Adams, Perry	Last Fri.
**Dixie, Lafayette*			
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.
**Flagler*			
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllve W. Dalton, Chipley	

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Vol. XL FEBRUARY, 1954 No. 8

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Carroll T. Bowen

Bacillary Dysentery Among University Students
Joseph M. Bistowish Jr.

Heart Disease
Simon D. Doff

Oath of Hippocrates

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Volume XL FEBRUARY, 1954 No. 8

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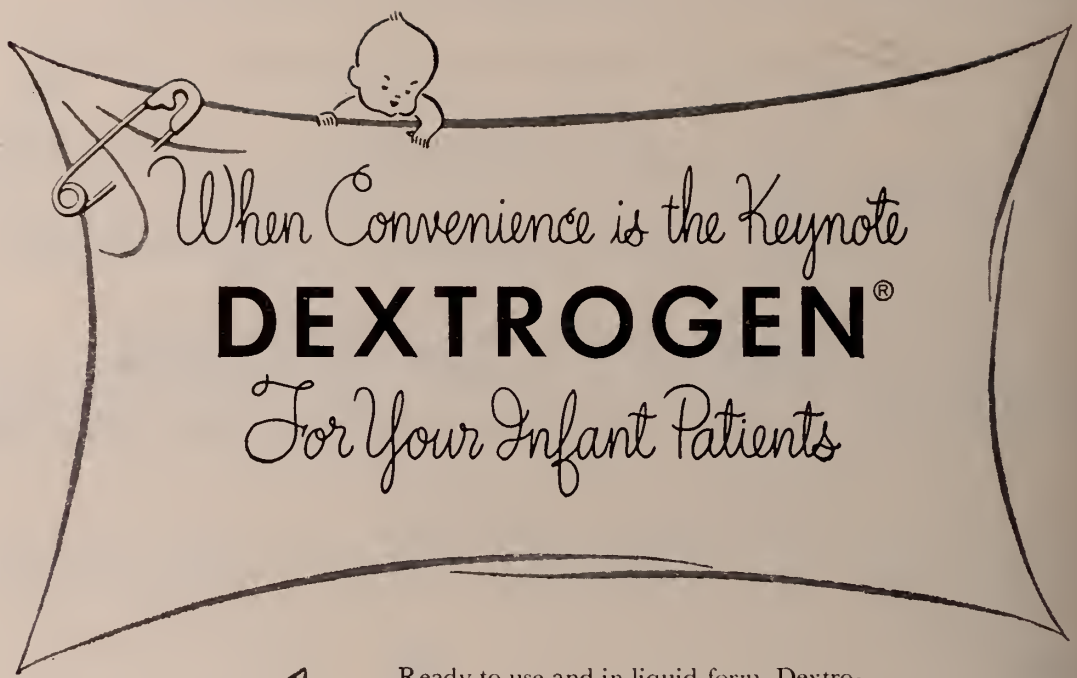
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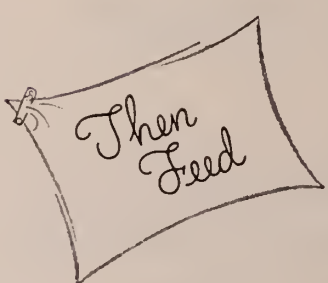
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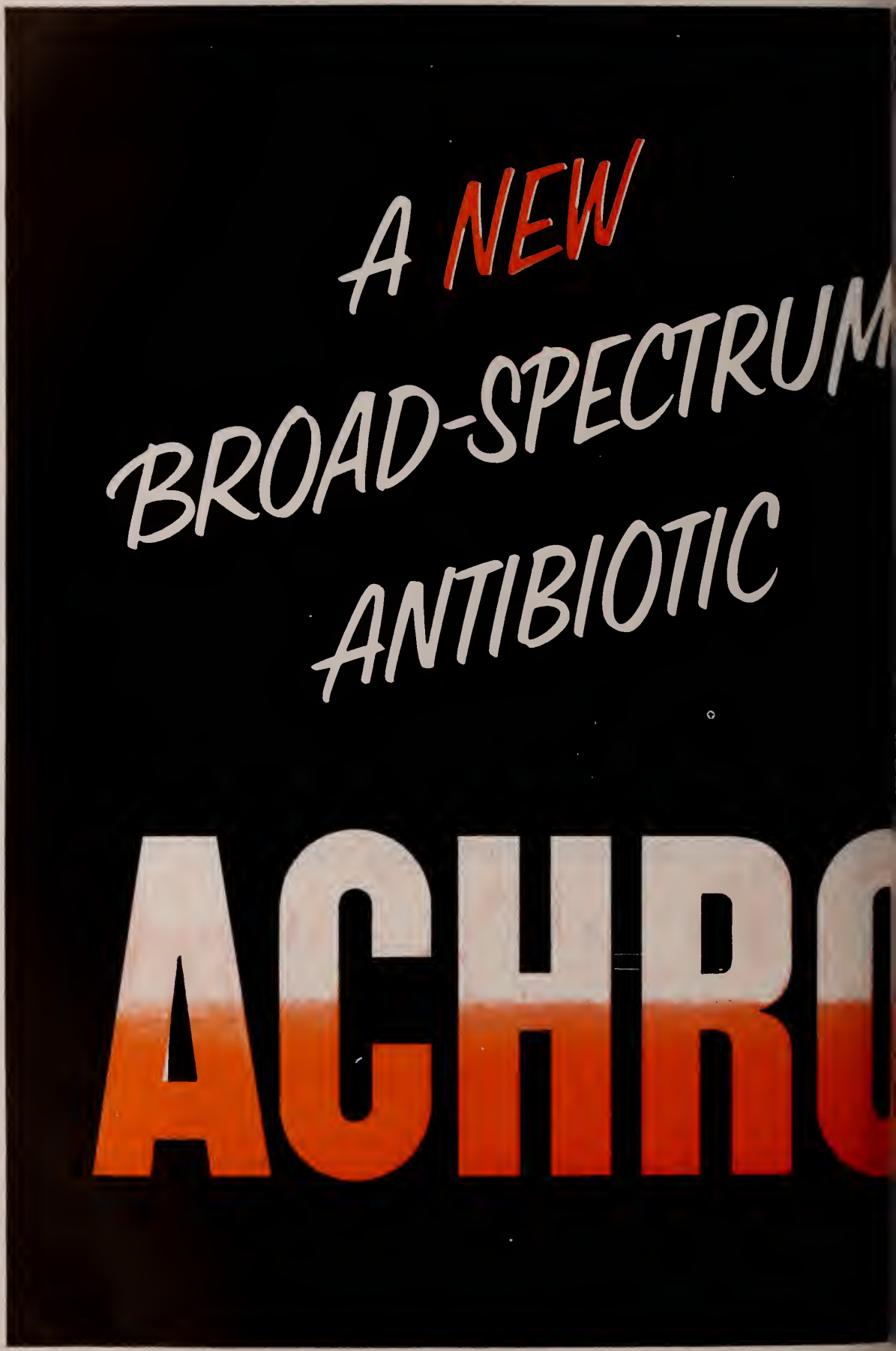
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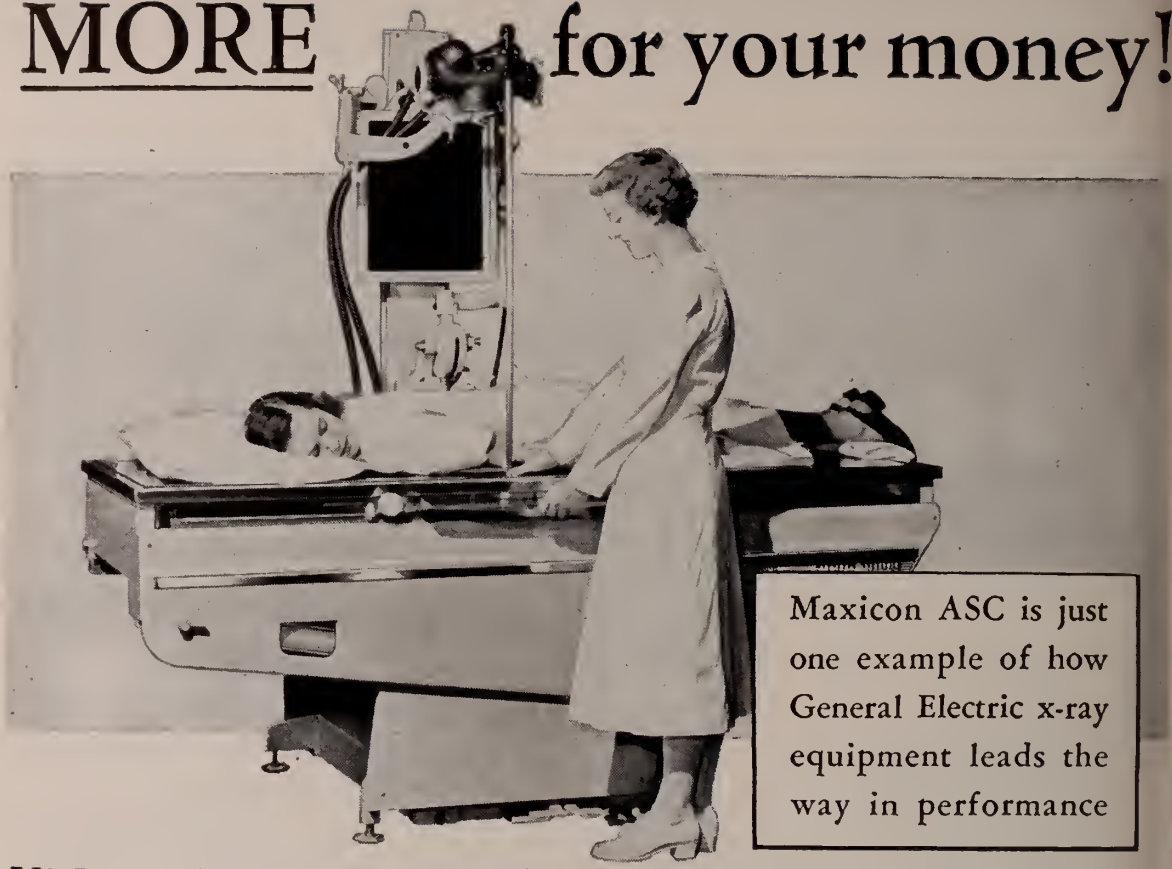
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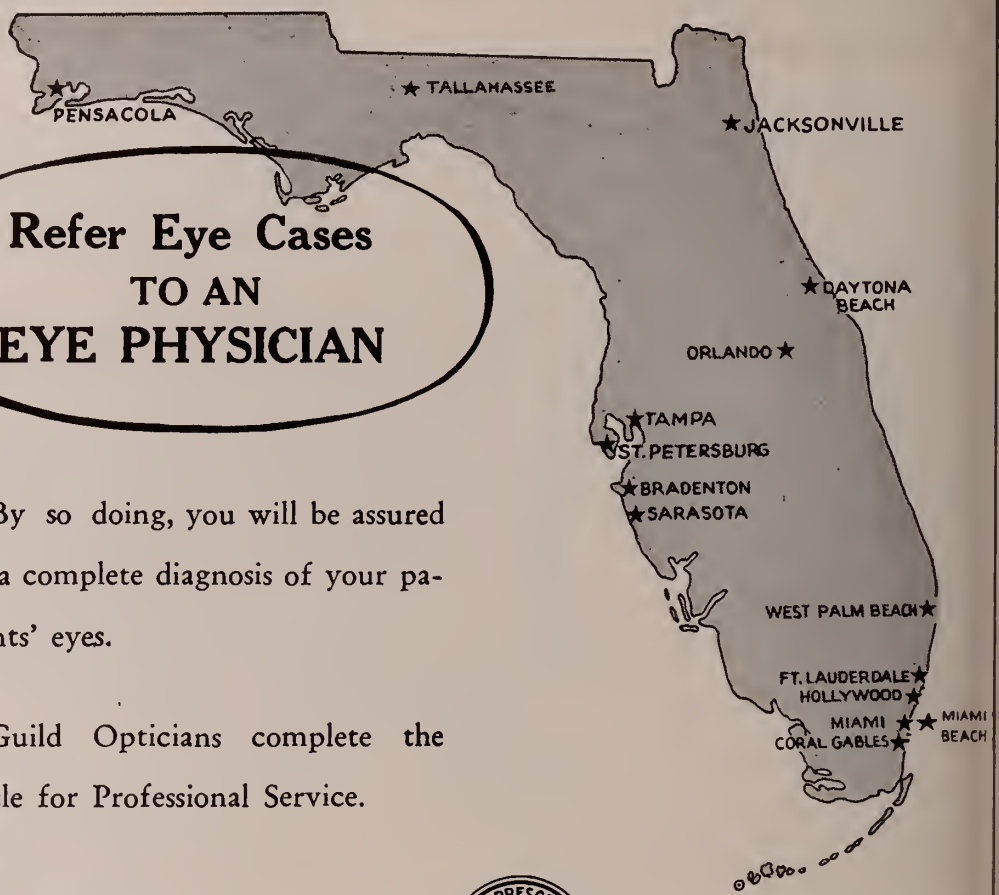
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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
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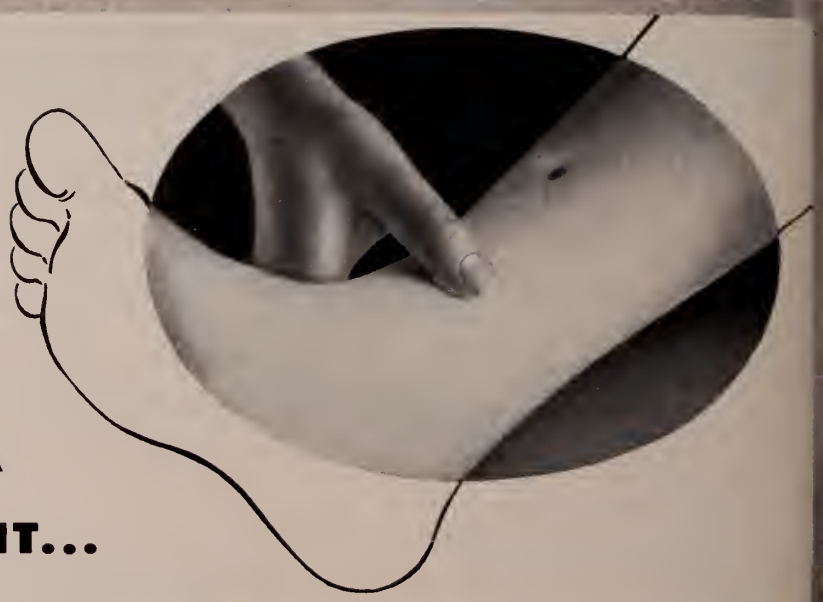
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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1. Grigsby, M. E., et al., Antibiot. & Chemother., 10:1029, October, 1953.

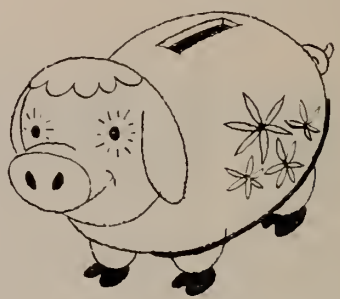
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Observations on Five Years Operation of the Dade County Venereal Disease Control System

Carroll T. Bowen, M.D.
MIAMI

The many changes occurring in venereal disease control which have become manifest in other parts of the nation have likewise become manifest in greater Miami. It is believed, however, that every venereal disease control officer who has lived through the years of rampant venereal disease, together with the years of rampant errors in diagnosis, and has had the honesty to admit to mistakes as well as success, may have been party to new ideas, procedures, and channels of thought, the recording of which might be beneficial to his fellows in the field.

It is well to state in connection with the Miami area that first of all it is an international tourist center and a city with one of the most transient populations on earth. The city is first in America in foreign aircraft travel and one of the greatest in growth. It should also be stated that the Dade County Venereal Disease Control System does dark field work for the armed services, the United States Public Health Service, which in turn takes care of foreign seamen, and of course for all civilian agencies.

The Health Department has maintained four venereal disease diagnostic and treatment centers. The Central Clinic, at 1401 Northwest Seventh Avenue, Miami, operates five mornings weekly and three nights weekly, while the three field clinics operate once weekly. It employs several part time local physicians, five nurses, several clerks, a laboratory technician, three follow-up investigators, and an x-ray technician.

From the Dade County Health Department, Turner E. Cato, M.D., M.P.H., Health Commissioner, and Carroll T. Bowen, M.D., Director of Venereal Disease Control, Miami.

Treatment has been free, there being no social service. The Dade County Health Department has likewise been favored by an extremely efficient and a highly cooperative police department, both in the city and in the county.

The contact and follow-up system is unique in health departments and was chiefly devised by Miss Iris Wilson, nursing supervisor of the clinic. The system leaves no loopholes on patient follow-up and is probably equal in efficiency to any peg-board type follow-up system in the nation.

Policy

Like other clinics, the Dade County Clinic has certain individual characteristics. For example, staff members do not hesitate to make out police warrants in cases of gonorrhea and syphilis when the patient refuses to take treatment. Warrants are also used on contacts in cases of early syphilis or gonorrhea whenever indicated. Each case is carefully studied, however, before police action is taken, and the venereal disease division always sends investigators and special letters to persons involved prior to any police action. In potentially infectious cases of syphilis, the patient is held in jail for treatment, and gonorrhea contacts and those known to have the disease are released after a single 600,000 unit dose of penicillin. It is necessary, however, for them to return to the clinic for two check-ups.

On Dec. 1, 1952, the clinic began to treat all gonorrhea contacts on an epidemiologic basis, and at present, reported gonorrhea cases have fallen from a present national average of approximately 68 per cent of our all time high in 1947 to a low

of 37 per cent of the 1947 level. The Dade County high figure in 1947 was 3,700 cases. The 1952 figure was 1,700 cases, and our estimate for 1953 is 1,400 cases. This decrease is increasingly interesting, since Dade County has had a population increase since 1947 of approximately 200,000 people. Likewise, in any case in which there is clinical evidence of gonorrhea, the patient is given treatment. Increasing evidence suggests therefore that epidemiologic treatment of contacts can be recommended in venereal disease control, and to date in none of our cases has the patient refused such treatment.

The clinic attempts to perform spinal taps in all cases of syphilis and has been most successful. The spinal tap is handled in an entirely casual manner and given no more concern than a blood test. A study of spinal tests performed in so-called bona fide cases yielded approximately 8 per cent seropositive results and 3 per cent positive active fluids.

It has been our observation that in 89 per cent of over-all cases of syphilis some degree of positivity is retained after treatment. This 89 per cent figure was obtained by study of the records of 1,000 diagnosed and treated cases of syphilis taken from our files in alphabetical order. In 6 high titer penicillin-treated cases, intensive treatment with Mapharsen-bismuth therapy did not alter the serologic picture after two years of observation.

For the past three years our clinic has omitted treatment in all previously treated pregnancy cases provided the treatment was certified and adequate. This policy was followed regardless of the height of the patient's titer. In cases in which there is a positive reaction, however, the patient is watched during pregnancy for persistent rise of titer. In three years, we have not seen a syphilitic child from a mother handled in this manner. We have had, however, many children born with positive serologic reactions, the peak titer being 16 Kahn units. It is my theory that the height of titer in the mother affects the reagin carry-over to the child. In one mother with 128 Kahn units, the child's blood did not give a negative reaction for a period of six months. It is therefore obvious that the so-called three month waiting period on the infant must at times be altered upward.

Another observation which has been most distressing has been the relationship of clinical syphilis to serologic syphilis. For many years we have considered standard blood tests for syphilis as criteria for treatment. Observation showed too many thousands of cases in which patients without a history of syphilis and without any clinical signs or symptoms were branded with the diagnosis of and treatment for syphilis. It was thought that the number of false positive reactors was far greater than the world believed. As a result of this belief, the clinic has taken a careful attitude concerning the diagnosis of syphilis. Each patient is treated with great care as to the possibility of psychologic trauma.

Fortunately, the Dade County Clinic has had the advantage of a carefully operated Treponema pallidum immobilization (T.P.I.) research program under the direction of Dr. Vincent R. Saurino. This program was recently terminated due to difficulties arising at the Dade County blood bank. The numbers of cases in which positive reaction to VDRL, Eagle, and Kahn tests shown negative by repeated T.P.I. tests are constantly rising.

In one 68 year old patient who had always given a negative reaction until two years ago there developed a persistently positive serologic reaction of 32 Kahn units; yet, her history, physical examination and a series of T.P.I. tests gave no evidence of syphilis. It is believed, therefore that serodiagnostic tests for syphilis showing the high Kahn titer mentioned can be fallacious. With such strange findings, a chill develops in the conscientious clinician who must rely on serology as a criterion for diagnosis in history-free, symptomless cases.

It has been our observation that doctors are becoming increasingly embarrassed in their attempt to diagnose syphilis from reagin type serologic tests. Much faith is being lost in all forms of standard reagin diagnostic tests in this area. Doctors of lesser information still consider serologic tests as the law of the land, and physicians of questionable ethics could be pleasantly benefited from these nonspecific tests.

It was easy for us to be right when we did not think we were wrong, but it is difficult to be right when we realize that our chance for error in serologic diagnosis of latent syphilis may be as high as 40 or 50 per cent. This situation, however presents a challenge which will no doubt eventually be met, even though the challenge is of baffling magnitude.

Our past has left us with certain misunderstandings which must be corrected. One of the worst of these is the belief by most patients and many doctors that the various reagin serodiagnostic tests are truly diagnostic in character.

Table 1. — Dade County Health Department Clinic, Five Year Resume

Division of Venereal Disease Control	1948	1949	1950	1951	1952
Blood tests for syphilis	22,805	25,741	23,281	18,343	18,938
Smears for gonorrhea	12,220	8,449	2,470	2,953	5,104
Cultures for gonorrhea	11,051	10,076	8,385	8,123	6,995
Dark field examinations	567	494	284	136	84
Positive dark field examinations	124	106	44	16	9
Spinal fluid examinations	602	494	715	890	744
Treatments given	12,221	17,396	13,483	9,093	8,456
Clinic visits	36,515	36,522	40,908	35,327	31,707
Field visits	11,949	12,545	11,499	12,669	16,799
Syphilis rapid treatment	1,082	1,317	1,131	616	608
Police warrants	278	122	91	85	118
Letters to delinquent patients	7,402	6,049	8,074	5,657	6,176
Patients interviewed	4,107	4,483	4,027	3,138	2,609
Premarital blood tests			525	705	551
Night clinic cases			7,020	5,751	5,394

Subsequent to the closing of the State Rapid Treatment Center at Melbourne, the various health departments have had the privilege of treating their granuloma inguinale cases. Our observation places chloromycetin at the top of the efficiency list as far as oral medication is concerned.

The Dade County Clinic, however, within the past year rendered streptomycin treatment on an ambulatory basis to 6 patients. Each patient received 1 Gm. of streptomycin in 4 cc. sterile 1 per cent novocain solution intramuscularly five mornings per week and three nights per week until 24 Gm. had been given. In all of the cases recovery was rapid, and no remissions were noted four months after the last case was treated. Likewise, no untoward results occurred.

The Dade County Health Department Clinic for the past five years has adopted the theory that penicillin is cheap insurance in the treatment of syphilis. While many other clinics have used lesser amounts, the Dade Clinic believes that in most cases the patient receives inadequate treatment. Our schedule for the use of pencillin with aluminum monostearate and procaine is as follows:

Primary: 600,000 units per day for ten doses.

Secondary, early and late latent: 600,000 units per day for twelve doses.

Active involvement of the central nervous system: 600,000 units daily for twenty doses.

The results from this heavy treatment schedule for syphilis are interesting considering the large size of the clinic. We have not seen a single case of clinical remission and only 6 cases of probable serologic remission over a period of five years.

Concerning additional points of interest pertaining to the clinic, it is well to mention that in the five year period we had 6 patients severely allergic to penicillin requiring bed rest and adrenalin. The usual mild allergy, however, either general or localized to the site of injection, responded to pyribenzamine therapy.

Dark field examinations of all suspicious lesions are made in our field clinics. The cover glass is sealed to the slide by touching the edges with a thin strip of neutral petrolatum. These slides are then examined at the central clinic. Such specimens taken at 3 p.m. on one day and placed in the refrigerator over night showed motile Treponema pallidum at 9 a.m. the following morning. Care should of course be taken to see that these specimens are kept as cool as possible.

The clinic likewise has made considerable use of capillary blood testing on infants when veins could not be demonstrated. A slight incision on

the lobe of the ear or side of the foot near the heel has given most satisfactory results. The secret of such blood taking lies in keeping the tube on a horizontal level and prevention of bubbles by approximation of the tube to the site of bleeding.

It is also interesting to note that cases in which there were dark field positive results in the Dade County Clinic dropped from an average of more than 10 per month in 1948 to a total of 9 cases for the year of 1952.

Table 1 shows some of the production figures of the Dade County Clinic covering five years of operation.

Conclusion

As a result of the past five years of observation, it is concluded that certain impressions concerning the venereal disease control program can be safely drawn.

1. Without continued control which includes not only treatment but a most efficient interview and follow-up system, the incidence of venereal disease will rise.

2. With special emphasis on high school students, education of the general public should receive more attention in the over-all program.

3. It is considered that many State Health Departments should maintain a well operated T. pallidum immobilization testing center for aid in diagnosing symptomless cases with no history of syphilis.

4. The various reagin tests are subject to errors of such magnitude that much greater research effort should be expended to accomplish accurate diagnosis in latent symptomless cases. Indeed, the greatest problem concerning syphilis today lies in accurate diagnosis of symptomless cases.

5. It is preferable to err on the side of excessive use of penicillin in therapy for syphilis. The rewards justify the expenditure.

6. Physicians should explain to the patient the possibility of error in the diagnosis of latent syphilis so that even though the patient may receive treatment, he will also understand that the treatment does not brand him as certainly having syphilis.

7. The cardiolipin type serodiagnostic tests, if sensitized at a level which will not pick up too much normal blood reagin, probably represent the best tests of the reagin type.

8. An attempt to prove the efficiency of any type of serodiagnostic test should not be made from such erroneous sources of diagnosis as "history of previous penile sore or previous treatment," since these sources are likewise subject to error.

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Mortality Trends in Florida

Everett H. Williams, Jr., M.S.
Jacksonville

The purpose of this paper is to indicate the amount of decrease in the forces of mortality in Florida during the period 1920-1950 by showing the trend of death rates according to age, race, sex, and cause of death.

In studying the trend of mortality, it is necessary to consider changes which have taken place in the composition of the population. There is a wide variation in death rates for various age groups, and there are also significant differences among death rates classified according to race and sex. This variation in death rates is shown graphically in figure 1, which contains age-specific death rates by race and sex for Florida for the year 1950. Mortality is relatively high among infants under 1 year of age. It drops rapidly after the first year of life, reaches a minimum in the 5-14 year age group and then gradually increases throughout life. Death rates are not shown for those persons 75 years of age and over, but they are roughly twice as high as rates for the 65-74 year group. Mortality rates are lower for the white race than for nonwhites, and female death rates are lower than corresponding rates for males.

Because of these variations in death rates, one would expect a population which has a high proportion of older persons, males, or nonwhites to have a relatively high crude death rate. On the other hand, a population with a high proportion of young persons, females, or whites would be expected to have a relatively low crude death rate. In order to get a true picture of differences in mortality experience, it is advisable either to study age-specific death rates for each race and sex or to compare "adjusted" death rates which compensate for differences in composition of population.

This paper contains a comparison of data for the years 1920, 1930, 1940, and 1950. These years were selected because they were years in which a federal census was taken and population figures are therefore more accurate.

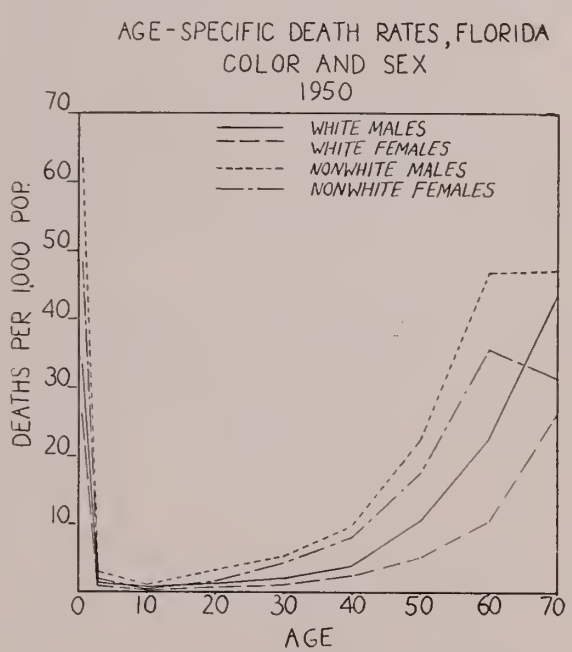
Director, Bureau of Vital Statistics, Florida State Board of Health.

Read before the Florida Health Officers' Society, Eighth Annual Meeting, Hollywood, April 26, 1953.

Population Changes

An examination of census data shows that the population of Florida is steadily growing older and that the proportion of nonwhite persons is growing smaller. The median age of persons in this state in 1920 was 24.0 years. This increased to 25.8 in 1930, 28.9 in 1940, and 30.9 in 1950. In 1920, only 4.2 per cent of the population was over 65 years of age. This figure was more than doubled in 1950 when 8.6 per cent of the population was over 65. The proportion of nonwhite persons has decreased from 34.1 per cent in 1920 to 21.8 per cent in 1950.

FIG. 1



Age-Specific Death Rates — (Table 1)

Age-specific death rates for white females for each decade are compared in figure 2. This chart shows there has been a steady decrease in mortality for every age group between each 10 year period. While the largest absolute decrease took place in the under 1 year group, the highest percentage decrease took place in the 1-4 year age group where the death rate decreased from 9.0 in

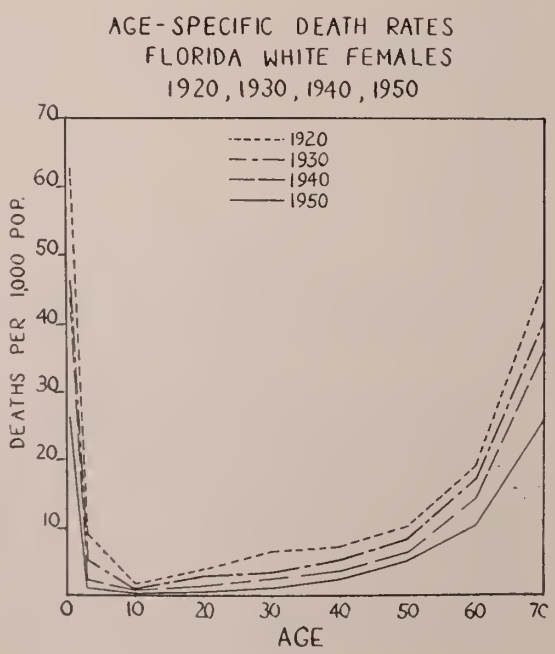
Table 1. — Age-Specific Death Rates, by Color, and Sex, Florida, 1920, 1930, 1940, and 1950

Age Group	White Males				White Females			
	Resident		Recorded		Resident		Recorded	
	1950	1940	1930	1920	1950	1940	1930	1920
-1	33.38	56.06	56.48	84.02	26.09	44.12	46.33	62.73
1-4	1.35	2.76	5.47	9.76	1.04	2.07	5.09	9.03
5-14	0.82	1.25	1.67	2.67	0.35	0.85	1.02	1.95
15-24	1.70	2.05	3.20	4.63	0.74	1.33	2.86	3.90
25-34	2.07	3.51	4.81	5.96	1.07	2.43	3.60	6.73
35-44	3.99	5.85	7.05	8.09	2.52	3.58	5.38	7.33
45-54	10.69	12.85	13.86	14.09	5.16	6.27	8.53	10.32
55-64	22.64	25.24	29.06	24.92	10.46	12.92	17.43	19.43
65-74	43.46	49.36	56.29	50.28	26.25	31.89	40.80	46.44
75+	99.65	125.58	128.47	119.70	82.88	104.89	119.18	116.91

Age Group	Nonwhite Males				Nonwhite Females			
	Resident		Recorded		Resident		Recorded	
	1950	1940	1930	1920	1950	1940	1930	1920
-1	63.63	110.27	123.78	137.48	48.36	75.61	93.82	110.03
1-4	3.03	6.07	9.05	11.57	1.96	4.62	8.38	8.70
5-14	1.20	1.46	2.77	3.41	0.58	1.32	2.25	2.83
15-24	3.35	5.77	8.15	9.18	1.78	5.01	7.14	9.45
25-34	5.43	11.69	12.45	12.09	4.41	7.61	11.40	12.53
35-44	9.88	15.54	20.65	17.07	8.23	14.13	17.44	16.24
45-54	22.55	31.27	32.79	18.76	17.82	25.18	29.16	21.64
55-64	46.88	48.00	46.98	29.17	35.64	41.52	42.13	30.88
65-74	47.21	55.70	75.42	56.68	31.71	40.12	50.01	52.37
75+	86.45	119.35	131.33	135.82	68.84	87.04	114.20	122.63

1920 to 1.0 per thousand population in 1950. During the 10 years prior to 1950, all age groups for white females decreased at least 18 per cent. Although charts for white males, nonwhite males, and nonwhite females are not included, they would show essentially the same picture with the exception that nonwhite rates for the year 1920 are apparently too low, probably because of under-reporting of nonwhite deaths in that year.

FIG. 2



Adjusted Death Rates — (Table 2)

While a study of death rates for specific age groups is preferable, it is sometimes desirable to consolidate these into a single age-adjusted rate. By applying the age-specific death rates to a standard population which remains fixed, a more comparable death rate can be obtained. This is the mortality rate which the standard population would have experienced if acted upon by the age-specific rates. The standard population which has been used is one in which the number of persons for each race and sex group of the 1940 United States population are given the same age distribution as the total population. The use of this population will give an age-race-sex adjusted death rate.

Age, race, and sex adjusted rates for Florida are as follows: 1920, 13.6; 1930, 12.5; 1940, 10.4; and 1950, 7.9 per thousand persons. There was a 24 per cent decrease between 1940 and 1950. The mortality rate for Florida in 1950 was 10 per cent lower than the comparable rate for the United States.

The trend of age-adjusted death rates for each race and sex and comparable United States figures are shown in figure 3. During the period 1940-1950, the following decreases were recorded: white males 21 per cent, white females 25 per cent, nonwhite males 27 per cent, and nonwhite females 30

Table 2. — Age-Adjusted Death Rates, by Race and Sex, Florida, and Death-Registration States of the United States 1920, 1930, 1940, and 1950

YEAR	Age, Race, and Sex Adjusted* Death Rates	AGE-ADJUSTED DEATH RATES			
	TOTAL	White Males	White Females	Nonwhite Males	Nonwhite Females
FLORIDA					
1950	7.9	9.1	5.6	14.7	11.0
1940	10.4	11.5	7.5	20.1	15.8
1930**	12.5	13.1	9.8	23.3	19.5
1920**	13.6	13.8	12.1	19.5	18.8
UNITED STATES					
1950***	8.8	9.9	6.9	14.1	11.0
1940	10.8	11.6	8.8	17.5	14.9
1930	12.6	12.8	10.6	21.0	19.2
1920	14.4	14.2	13.1	20.4	21.0

*Total adjusted by race and sex as well as by age.
**Based upon recorded deaths. Resident deaths by ages not available.
***Based upon estimates of age-specific death rates as released by the National Office of Vital Statistics.

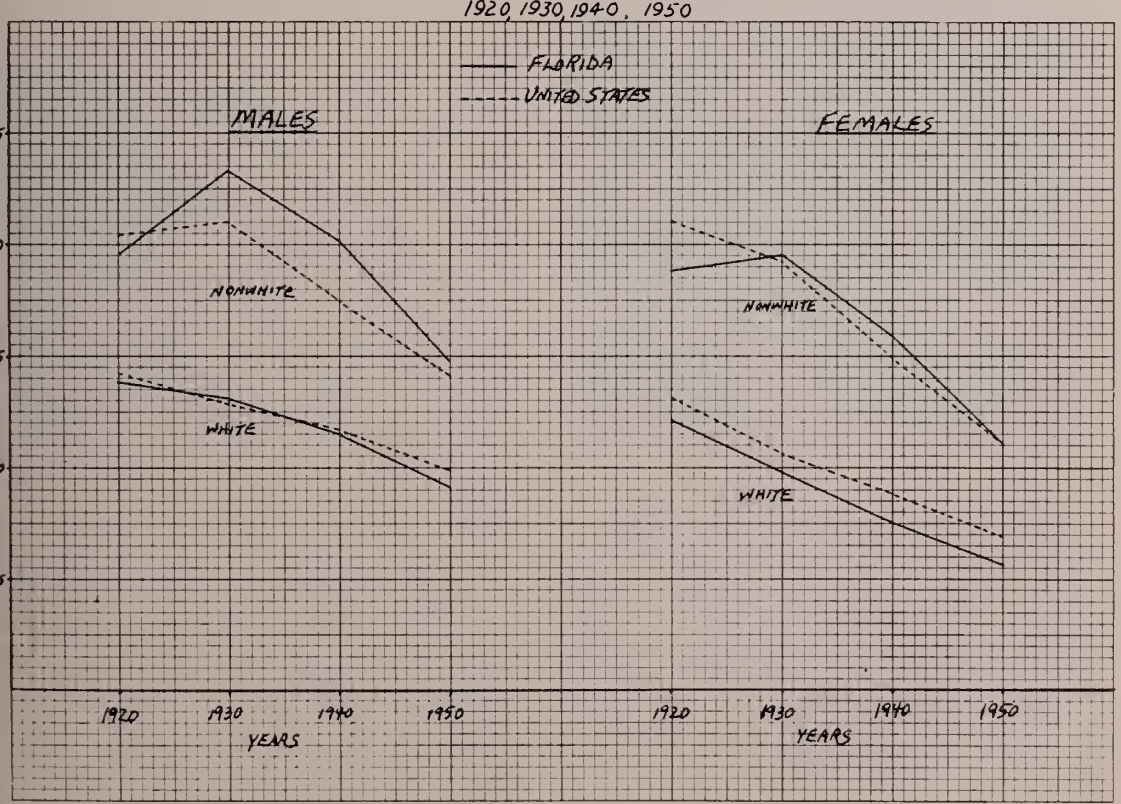
ber cent. The gap between the white and non-white groups decreased during this 10 year period. In comparing Florida figures for 1950 with those for the United States, one can see that white mortality rates are lower in Florida, while nonwhite rates are higher and the nonwhite female rates are the same.

Deaths From Major Causes

In order to study mortality trends according to cause of death, age-specific death rates and age-adjusted death rates for each race and sex have been tabulated for six of the major cause groups for the years 1930, 1940, and 1950. These rates have been plotted on a logarithmic scale so

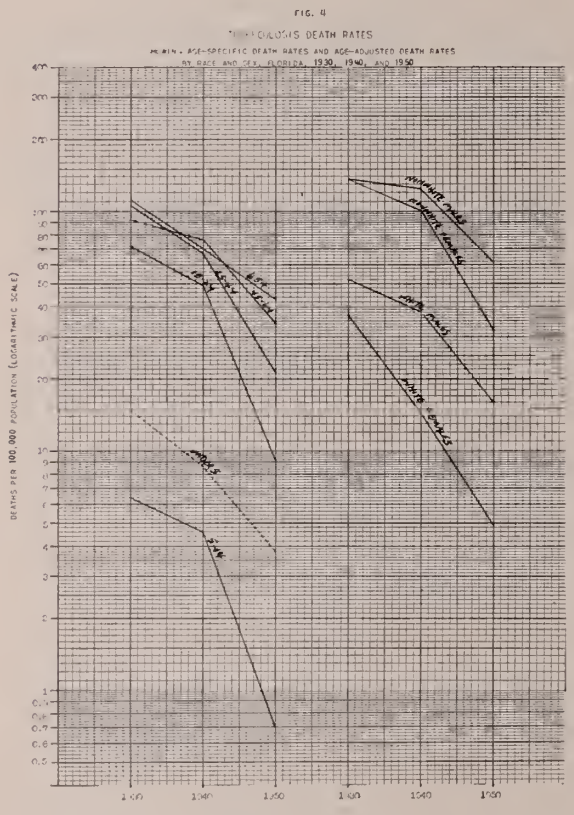
FIG. 3

COMPARISON OF AGE-ADJUSTED DEATH RATES, FLORIDA AND THE UNITED STATES 1920, 1930, 1940, 1950

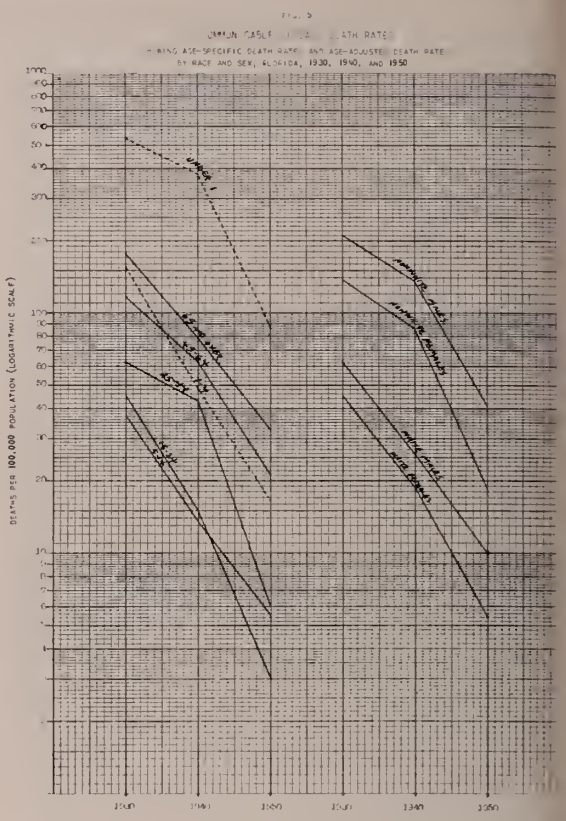


that percentage increase or decrease can be more easily compared. On a logarithmic scale, the lines will be parallel if the percentage change is the same.

The first of these diseases is tuberculosis, and the death rates are plotted in figure 4. This chart shows that, with the exception of those under 5 years, the risk of dying from tuberculosis increases with age and that the greatest proportionate decrease has been in the younger age groups. Much improvement, however, has taken place in all groups. Nonwhite rates are considerably higher than white rates, and male rates are higher than those for females. Both white and nonwhite mortality is decreasing at about the same rate, but female rates have a greater percentage decrease than those for males.



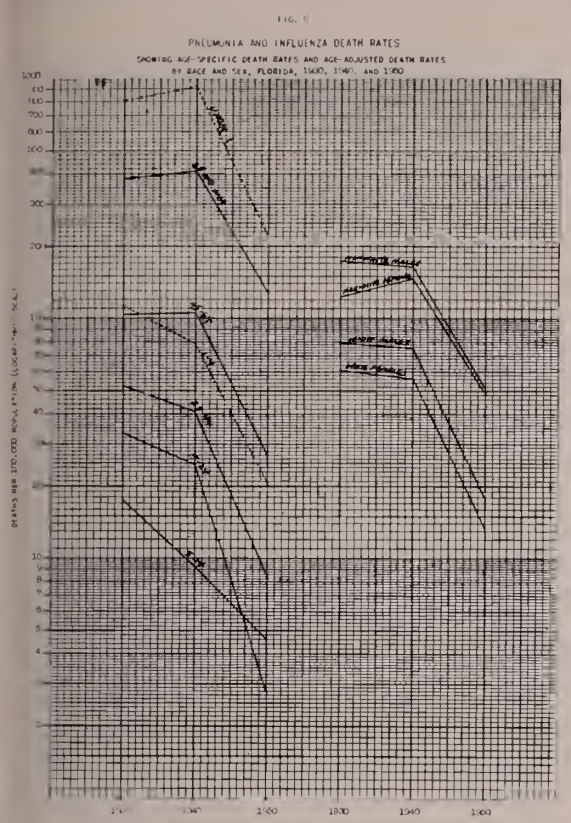
All other communicable diseases have been grouped together, and death rates are plotted in figure 5. Infants under 1 year of age have the highest mortality from these causes, and the 1-4 group is relatively higher. Here again, nonwhite rates are higher than those for whites, and rates for males are greater than those for females. There was much improvement during the decade since 1940, and all groups have roughly the same proportionate decrease.

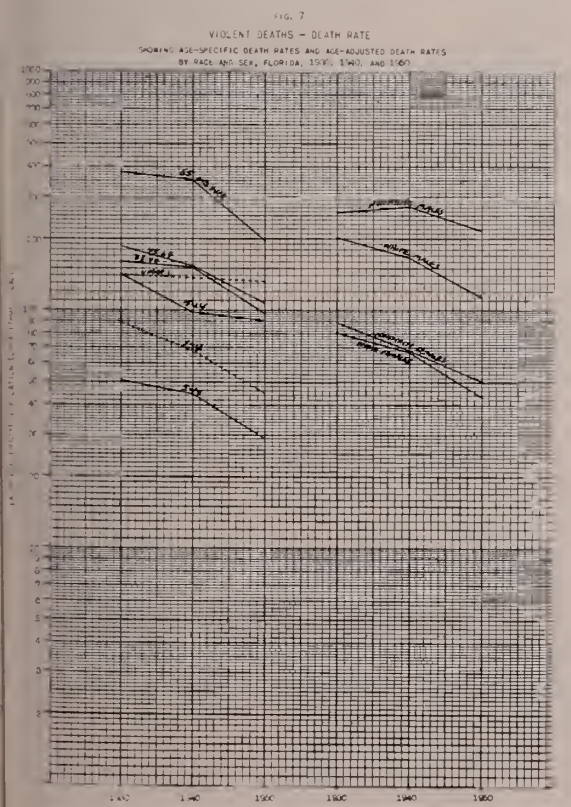


The next group to be considered covers deaths due to pneumonia and influenza (fig. 6). Here also, mortality is relatively high in the under 1 and 1-4 year age groups. Nonwhite rates are higher than those for whites. The difference between male and female rates is smaller, but the male rates are still greater. There was much improvement in all rates during the period 1940-1950.

Deaths due to accidents, homicide, and suicide are grouped under the heading of "violent deaths" (fig. 7). Mortality is decreasing for this group, but the improvement has been much less than for the previously discussed diseases. It is noteworthy that there has been practically no decrease in rates for infants under 1 year of age. As would be expected, mortality for males is much higher than that for females.

Cancer is one disease for which mortality is not decreasing. Male and female rates present a different pattern in this disease and, for this reason, age-specific rates for both sexes of the white race are included in figure 8. For all ages over 35, the rates for males are increasing more rapidly than those for females. In fact, several age groups among the white females decreased

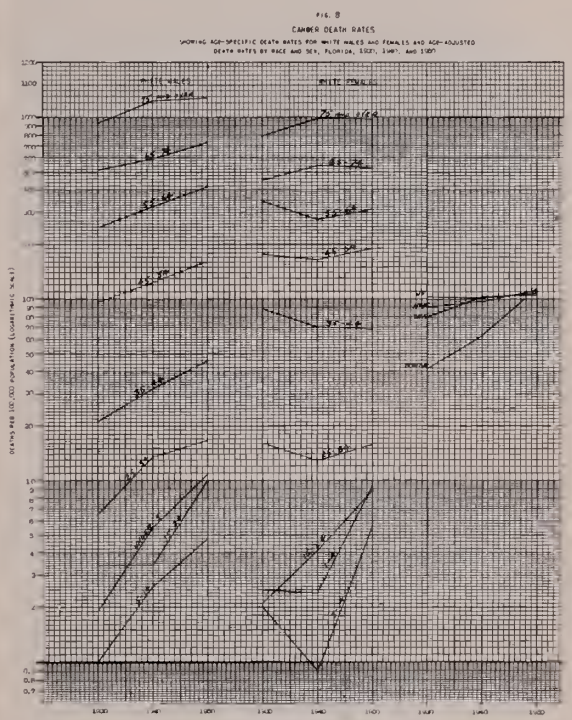




between 1940 and 1950. Cancer has shown a rapid increase in persons under 25 years of age. In 1950, the age-adjusted death rates for all race and sex groups were almost identical.

The last cause group to be considered is one for the cardiovascular-renal diseases (fig. 9). While the improvement from these causes has not been as spectacular as that for the acute diseases, there has been a steady decline in all groups. This improvement amounted to about 25 per cent between 1940 and 1950.

It is particularly important to make adjustments for age distribution when one considers cancer and the cardiovascular-renal diseases. These diseases predominantly occur in persons in the older age groups and, therefore, are influenced greatly by the proportion of older persons in the population.



Life Expectancy — (Tables 3 and 4)

Another method of studying mortality patterns is through life expectancies as computed by life table methods. This shows the average future lifetime which persons at any given age might expect if they are affected by the age-specific death rates for a particular period. It is customary to average deaths for a three year period to eliminate minor fluctuations in age-specific death rates.

Table 3. — Average Future Lifetime for Total Population, Florida, 1929-1931, 1939-1941, 1949-1951

AGE (In Years)	AVERAGE FUTURE LIFETIME (IN YEARS)		
	1949-1951	1939-1941	1929-1931
-1	67.71	61.20	56.60
1	69.23	63.88	59.24
2-4	68.40	63.27	58.87
5-9	65.64	60.74	56.59
10-14	60.87	56.08	52.13
15-19	56.04	51.40	47.53
20-24	51.38	46.97	43.40
25-29	46.82	42.75	39.58
30-34	42.28	38.63	35.79
35-39	37.81	34.64	32.09
40-44	33.47	30.69	28.43
45-49	29.33	26.94	25.00
50-54	25.19	23.42	21.66
55-59	21.66	20.19	18.53
60-64	18.39	17.09	15.51
65-69	15.28	14.05	12.72
70-74	12.25	11.13	10.15
75-79	9.60	8.54	7.99
80-84	7.30	6.57	6.21
85-89	5.46	4.95	4.92
90-94	4.23	3.89	3.85

Table 4. — Comparsion of Average Future Lifetime, by Color and Sex, and by Age Groups, Florida, 1929-1931, 1939-1941, and 1949-1951

Age Groups	AVERAGE FUTURE LIFETIME (IN YEARS)											
	White Males			White Females			Nonwhite Males			Nonwhite Females		
	1949-1951	1939-1941	1929-1931	1949-1951	1939-1941	1929-1931	1949-1951	1939-1941	1929-1931	1949-1951	1939-1941	1929-1931
Under 1	66.71	62.40	59.26	73.97	68.80	64.20	56.47	49.37	45.47	62.18	54.44	48.85
1	67.89	64.73	61.48	74.80	70.86	66.08	58.88	53.39	49.48	64.24	57.57	52.23
2-4	67.02	64.04	61.00	73.94	70.17	65.63	58.18	52.98	49.39	63.47	57.09	51.99
5-9	64.25	61.46	58.73	71.13	67.55	63.33	55.50	50.63	47.11	60.77	54.56	49.73
10-14	59.49	56.81	54.32	66.27	62.84	58.81	50.77	46.08	42.69	56.01	49.87	45.23
15-19	54.66	52.15	49.71	61.39	58.03	54.09	46.69	41.48	38.23	51.17	45.26	40.72
20-24	50.04	47.61	45.40	56.57	53.40	49.65	42.20	37.32	34.38	46.53	41.14	37.07
25-29	45.50	43.24	41.27	51.78	48.80	45.44	38.01	33.58	31.06	42.06	37.32	33.63
30-34	40.94	38.90	37.11	47.01	44.29	41.17	33.86	30.06	27.91	37.85	33.56	30.21
35-39	36.37	34.59	33.05	42.31	39.88	37.04	29.84	26.86	24.78	33.82	30.01	27.09
40-44	31.91	30.33	28.98	37.70	35.47	32.89	26.03	23.59	21.88	29.89	26.57	23.96
45-49	27.66	26.31	25.12	33.20	31.10	28.86	22.50	20.65	19.42	26.29	23.66	21.24
50-54	23.67	22.59	21.42	28.84	26.94	24.85	19.30	18.11	16.92	23.13	20.90	18.68
55-59	20.09	19.06	17.94	24.62	22.87	20.98	17.09	16.32	14.87	20.69	19.30	16.70
60-64	16.90	15.91	14.80	20.53	18.96	17.32	15.48	14.70	12.66	18.83	17.79	15.25
65-69	14.00	12.97	12.09	16.64	15.30	13.95	13.96	12.96	10.59	17.41	15.95	13.31
70-74	11.29	10.25	9.61	13.09	11.88	10.94	11.69	10.72	8.63	14.53	13.31	11.27
75-79	8.92	7.84	7.58	9.96	8.97	8.38	9.75	8.73	7.42	12.34	10.96	9.05
80-84	6.80	6.09	5.84	7.38	6.66	6.50	7.77	7.06	5.77	10.18	8.93	7.10
85-89	5.06	4.40	4.71	5.36	4.89	4.93	5.93	5.81	4.98	8.05	7.55	5.59
90-94	3.79	3.31	3.47	3.95	3.72	3.94	5.79	4.44	3.70	6.22	5.82	4.57

FIG. 10

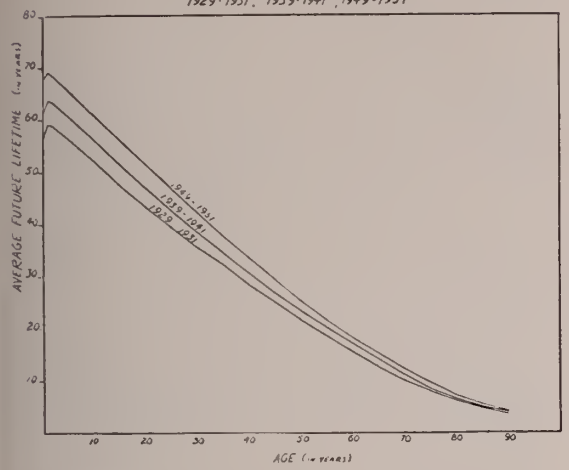
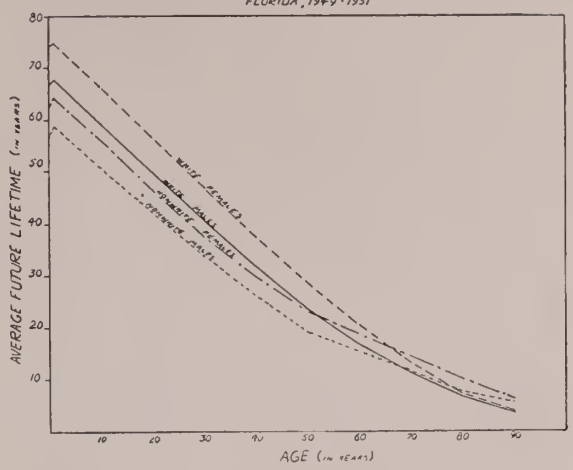


FIG 11



Life expectancy has improved in Florida from 56.6 years in 1929-1931 to 61.2 in 1939-1941 and then to 67.7 in 1949-1951. There has been a steady improvement in life expectancy for all ages as can be seen in figure 10. It is also interesting to note that while the average future lifetime at birth was 67.7 years in 1949-1951, an infant who survived the first year of life could expect to live an additional 69.2 years. This figure shows the effect of high mortality during the first year of life.

A comparison of life expectancy by race and sex for 1949-1951 shows the following results: White females, 73.9; white males, 66.7; nonwhite females, 62.2; and nonwhite males, 56.5 years (fig. 11). Apparently, the best way a person can insure a long life is to take the precaution to be born a female.

Outbreak of Bacillary Dysentery Among University Students

Joseph M. Bistowish, Jr., M.D.
TALLAHASSEE

This is a report on an outbreak of bacillary dysentery due to Shigella sonnei in a state university having an enrolment of 4,821 full time college students. Of the 4,821 students 2,248 are men and 2,573 are women. Approximately 93 per cent of the students live on the campus in dormitories and fraternity or sorority houses, while about 7 per cent live off the campus.

The university hospital admitted 250 students with dysentery during a period of 15 weeks, 214 of them within a five week period immediately following the annual Homecoming celebration. It is estimated that at least 2,000 additional students had symptoms, but sought no medical care or were cared for by private physicians.

Director, Leon County Health Unit.
Read before the Florida Health Officers' Society, Eighth Annual Meeting, Hollywood, April 26, 1953.

Clinical Picture

As in most outbreaks of bacillary dysentery, there was a wide variation of clinical severity. A relatively high proportion of the hospitalized patients, however, had the typical bloody mucopurulent evacuations, tenesmus, abdominal pain, nausea, fever, and general malaise. Many patients experienced 15 or more stools a day. Shigella sonnei was cultured from fecal specimens of most patients by the State Board of Health Regional Laboratory. In the average case the patient remained in the hospital about two and one-half days.

One case is worthy of particular mention. An 18 year old girl was admitted to the university hospital complaining of a sudden cramplike pain in the lower part of the abdomen. On the following day diarrhea developed, and S. sonnei was isolated from the stool. After a few days a mass became palpable in the lower part of the abdomen which did not extend into the true pelvis. It was thought that the patient had either an intestinal perforation caused by S. sonnei, or a ruptured appendix with a coincidental Shigella infection. A laparotomy was performed on the tenth day and an intra-abdominal abscess drained. While the surgeon could not be sure of the source of the abscess, it was his impression that it was probably due to a ruptured appendix. This case was followed with interest since perforation due to S. sonnei is relatively rare. Additional information on this case may be obtained in the near future since an appendectomy is planned soon.

Chronology of the Outbreak

University physicians normally hospitalize about 1 patient with diarrhea each week. During the four weeks' period preceding the annual Homecoming on Nov. 15, 1952, however, there were 11 admissions. This moderate increase in diarrhea was not thought to be significant at the time. The day following Homecoming there were 8 admissions, and within one week there had been 96 patients with dysentery hospitalized. The number of admissions decreased each succeeding week until during the week ending Jan. 24, 1953 there were 7 admissions. More complete data are presented in table 1.

Epidemiologic Investigation

When fecal cultures on the first patients had been found to be positive for S. sonnei, the County Health Department was consulted on Nov. 19, 1952. At that time, 38 patients had been hospitalized, 9 of whom had already been discharged.

Upon interviewing the patients it was learned that the only food or drink all of the patients consumed in common during the four days preceding the onset of symptoms was milk and water.

Water was not considered to be a likely mode of spread in this instance since all water on the campus was from the municipal supply and was found to have an adequate chlorine residual at several points.

In considering the possibility of a milk-borne outbreak, it was discovered that all of the first 38 patients during the four days preceding the onset of symptoms had consumed milk from either the university milk plant, or Milk Plant B in the city. Surplus milk from the university dairy was being sold to Milk Plant B. If milk from either source was in fact the vehicle, it would be reasonable, therefore, to expect some increase in diarrhea in the general population of the city. Apparently this was not the case, however, since only one private physician contacted thought that he was seeing more than the usual number of patients with this complaint. Inspections of both milk plants revealed that sanitation was generally good.

Table 1. — Weekly Incidence and Attack Rates per 1,000 Students Observed During an Outbreak of Bacillary Dysentery in a University

Week	Week Ending	Men		Women		Total	
		Number of Cases	Attack Rate	Number of Cases	Attack Rate	Number of Cases	Attack Rate
1	10/18/52	0	0	3	1.2	3	0.6
2	10/25/52	0	0	0	0	0	0
3	11/1/52	0	0	1	0.4	1	0.2
4	11/8/52	1	0.4	3	1.2	4	0.8
5	11/15/52*	0	0	3	1.2	3	0.6
6	11/22/52	12	5.3	84	32.6	96	19.9
7	11/29/52	20	8.9	25	9.7	45	9.3
8	12/6/52	15	6.7	18	6.9	33	6.8
9	12/13/52	11	4.9	12	4.7	23	4.8
10	12/20/52	9	4.0	8	3.1	17	3.5
11	12/27/52†						
12	1/3/53†						
13	1/10/53	3	1.3	4	1.6	7	1.5
14	1/17/53	1	0.4	10	3.9	11	2.3
15	1/24/53	1	0.4	6	2.3	7	1.5
Total		73	32.0	177	68.7	250	51.8

* Homecoming, Nov. 15, 1952.
† Christmas holidays.

and cultures of milk samples on several days were negative. Fecal specimens were obtained from all employees in both milk plants. Not a single specimen was found to contain S. sonnei, although Salmonella typhimurium was cultured from one specimen. In view of these findings and the additional knowledge that all milk sold in the city is pasteurized, it was thought that milk was probably not involved in the spread of dysentery.

No evidence could be obtained by interviews with patients incriminating any single restaurant or cafe as the source of the outbreak. It was found, however, that all of the first 38 patients had within three days of the onset of their symptoms eaten at one of two restaurants — the main university cafeteria, or a soda shop on the campus.

While this observation was not considered unusual, it was decided to investigate it further. A rigid inspection of the main university cafeteria revealed that sanitation and food handling practices were good. Furthermore, it was learned that in one dormitory of graduate women students there was not a single known case of diarrhea even though these students ate almost exclusively in the main cafeteria. No other women's dormitory or sorority house was found in which all of the women were free of symptoms. Stool cultures on all personnel revealed no carriers of S. sonnei, although two specimens were positive for S. typhimurium.

Inspection of the soda shop, on the other hand, was more fruitful. Several major defects in sanitation were found. Dishes and utensils were not being sanitized properly, flies were numerous, and the rest rooms were poorly maintained. A recommendation was made to university officials that the soda shop be closed until it had been thoroughly cleaned.

Stool cultures were also obtained on all employees of the soda shop. A Negro woman was found by repeated cultures to be carrying S. sonnei, although she had had no symptoms. This girl had been working in the shop for about five weeks without a health certificate. Her duties included dishwashing, setting tables, and cleaning the women's rest room. She was immediately taken out of the soda shop and placed under the care of a private physician.

Sex Incidence

During the early days of the outbreak, it seemed that the attack rate among women was greater than among men. By November 22 there had been seven times more women than men admitted to the hospital, while the ratio of women to men in the general student body was 1.14 to 1. It was thought that this difference might be more apparent than real. Perhaps the male students were more reluctant than the female to seek medical care. After questioning house mothers and officers of dormitories and fraternity and sorority houses, however, it was decided that dysentery was actually more prevalent among the women students.

As the epidemic progressed, the attack rate among the men, as judged by hospital admissions, approached that of the women. At the end of 15 weeks, the over-all attack rates for men and women were 32.0 and 68.7 per 1,000 students respectively (table 1). The combined attack rate for the university, considering only hospitalized cases, was 51.8 per 1,000 students.

Questionnaire

In order to obtain additional information regarding the extent of the outbreak among the students, a questionnaire was prepared. Included in the questionnaire were questions pertaining to history of symptoms, approximate time relationship of symptoms to various holidays, source of medical care, and food establishments frequented.

It was intended that these questionnaires be circulated among students in the classrooms so that a representative sample of male and female students of all classes living off and on the campus would be obtained. Because of an administrative error, the questionnaire was distributed in dormitories, thus excluding from the sample those students living off of the campus. Two days before the Christmas holidays 600 questionnaires were distributed, and 471 were completed and returned. Of the 471 returned, 199 had been completed by men and 272 by women. Fifty-one, or 25.6 per cent, of the men and 109, or 40 per cent, of the women had had symptoms by December 18. If these percentages are projected upon the entire enrolment, one determines that 576 males and 1,928 females, or a total of 2,504 students had symptoms prior to the Christmas holidays. These estimates, however, cannot be taken as accurate. Forty-three of the 272 women answering the questionnaire stated that they had been hospitalized. On the basis of this proportion, it would be expected that 406 women would have been hospitalized when actually only 157 had been hospitalized before the Christmas holidays. For

the men, however, the expected number of students hospitalized exactly coincided with the actual number of admissions.

The reason for the discrepancy in the results between men and women was not determined. Perhaps adequate explanation was not given the women when the questionnaires were distributed. Perhaps it was mere chance that such a large proportion of questionnaires was distributed to women who had been hospitalized. At any rate, although admittedly the results of the questionnaire are inaccurate, it is believed that there is evidence enough to assume that there were at least 2,000 cases of dysentery among the students between Oct. 12, 1952 and Jan. 24, 1953.

Discussion and Conclusions

An outbreak of bacillary dysentery due to S. sonnei among university students is described. Of 4,821 college students, 250 were hospitalized within a 15 week period. Within this same period it is estimated with reasonable justification that about 2,000 students actually experienced an attack of dysentery. It is also shown that during the early days of the outbreak, infections occurred predominantly in women students. As the outbreak progressed, the incidence among men increased greatly, although for the entire 15 week period considered there were probably twice as many women affected as men.

The possibility of this outbreak having been food-borne or water-borne has been, it is believed, ruled out, although it is likely that some infections were caused by contaminated food or drink.

It is thought that the dysentery in this outbreak was spread by personal contact — hand to mouth, so to speak. It is concluded that the single food handler found to be harboring S. sonnei is significant. This Negro girl had been working in the soda shop only one week when admissions to the hospital for diarrhea began to increase. It is possible that she infected chiefly women students by way of the rest room which she cleaned. As a few students became infected either as frank cases of dysentery or as asymptomatic carriers, the case rate rose slowly at first and then rapidly as more students became infected. It is thought that the higher rate of incidence among the female students occurred for two main reasons. Firstly, women students are probably more intimate with each other when living in dormitories than are men. Secondly, it is a common practice in most dormitories for women for various size groups of students to prepare midevening or midnight snacks.

Perhaps too much significance has been attached to the single positive food handler, though it is unusual to have found only one carrier among nearly 200 examined. It is possible this food handler became infected simultaneously with the students during the outbreak of the disease. It does seem reasonable to conclude, however, that the same progression of events could have occurred if one or more of the students had reported to school late in September as carriers of S. sonnei.

Box 1117.

THE EIGHTIETH ANNUAL CONVENTION

of the

FLORIDA MEDICAL ASSOCIATION

HOLLYWOOD BEACH HOTEL APRIL 25-28, 1954

Heart Disease
A Community Health Problem

Simon D. Doff, M.D.
Jacksonville

In the time allotted, I will present some of the evidence which should compel us to regard cardiovascular disease as a serious community health problem and advise you of the action we can take to coordinate our community health resources for the control of such disease.

Concerted efforts in the field of heart disease control are of short duration. Dr. Arlie R. Barnes of the Mayo Clinic and former president of the American Heart Association in a statement made before a Senate subcommittee hearing on the bill which created the National Heart Act in 1948 said: "The American Heart Association was founded in 1922. The objectives were for the study of and dissemination and application of knowledge concerning the causes, treatment and prevention of heart disease; the gathering of information on heart disease; the development and application of measures that would prevent heart disease; seeking and providing occupations suitable for heart disease patients; the promotion of the establishment of dispensary classes for heart disease patients; the extension of opportunities for adequate care of cardiac convalescents; the promotion of permanent institutional care for such cardiac patients as are hopelessly incapacitated from self-support." In 1946, he said: "This organization was changed, and its objectives were broadened to meet the urgent need for national action in solving the medical, social and economic problems of heart disease."

Dr. T. Duckett Jones, of rheumatic fever and rheumatic heart disease fame, said of the American Heart Association: "From 1922 to 1947 its interests and purposes were entirely scientific, largely for the edification and enjoyment of its own professional membership." It must be obvious from these statements that this organization appears not to have changed its stated objectives but rather its determination to carry them out.

The factors which made this change in emphasis imperative prompted Dr. Paul D. White, nationally known cardiologist, to state in his textbook on Heart Disease, published in 1944: "Heart Disease or rather Cardiovascular disease has become the chief public health problem of our day." I suspect that the term "public health" was used here in the general sense and not to indicate that the sole responsibility resided in the official health agency.

Florida Statistics

Statistics concerning cardiovascular disease are well known to all of you. While total deaths for the country as a whole ran well over half a million last year, it is not only the leading cause of death, but the major cause of disability as well with a morbidity of between nine and ten million. In Florida, the total number of annual deaths from cardiovascular disease (9,000 plus), exclusive of cerebral vascular accidents, is so large that even if we eliminate those occurring after age 65, the number of deaths under age 65 exceeds deaths from malignant neoplasms at all ages.

It is significant that among persons who receive financial aid from state welfare funds for permanent and total disability (under age 64), one fourth are disabled by heart disease. In Duval County, the Visiting Nurses' Association makes some 1,500 to 1,600 visits each month, of which one third are made to persons with heart disease.

Investigation of school children in Pensacola and in Miami indicates that rheumatic heart disease is prevalent in this group to the extent of approximately four per thousand and congenital heart disease in the same proportion. With the school population of the State of Florida running close to 800,000 at the present time, a little

Read before the Florida Health Officers' Society, Eighth Annual Meeting, Hollywood, April 26, 1953.

simple arithmetic will give us the approximate number of school children with cardiac disease.

Last year I asked the State Department of Welfare to determine to what extent diseases of the circulatory system were responsible for disability in the case of families receiving aid for dependent children. As of February 1952, an estimated 3,876 families were receiving assistance under the A.D.C. Program because of disability of a parent or guardian. Disease of the circulatory system was the cause of disability of the breadwinner in 1,008 cases, or 26 per cent of the total. The next largest were diseases of the nervous system, 17 per cent; diseases of bones and joints, 15 per cent; infectious and respiratory diseases including tuberculosis, 9.3 per cent. The remaining cases were divided more or less unequally among 11 other general causes of disability. From this information we can estimate that the economic load due to cardiovascular diseases in Florida in terms of welfare payments alone is more than $600,000 a year exclusive of costs for medical care, home nursing visits and other services, just in this small segment of the population.

Progress in Prevention, Diagnosis and Treatment

It is fair to say that neither the extraordinarily high mortality rate nor the obviously significant but limited morbidity data provide a sound basis for labeling cardiovascular disease a community health problem. What has changed the attitude of practicing physicians and public health physicians as well as legislators is to be found in a review of the progress which has been made in the prevention, diagnosis and treatment of cardiovascular disease and its complications during the last 12 to 15 years.

The diagnosis of congenital heart disease was relatively infrequently made during life a little more than a decade ago and, having been made, was of little more than academic interest. There was small incentive and no satisfactory diagnostic test to determine the precise nature of the congenital anomaly present, and there was no treatment but palliative. While most of the victims died before age five, a small percentage survived into adolescence and adult life. The perfection of cardiac catheterization technics and developments in the field of angiocardiography have presented the medical profession with invaluable diagnostic tools. In a period of a little more than ten years, methods for diagnosing every type of congenital anomaly of the heart and great vessels have been provided, and procedures for the correction of patent ductus arteriosus, coarctation of the aorta, tetralogy of Fallot, pulmonary artery stenosis, and interauricular and interventricular septal defects have been developed. The relationship of maternal rubella to the appearance of congenital anomalies in the offspring, the production of congenital anomalies experimentally in animals by low oxygen tension, and nutritional deficiency states have opened up a new field in experimental epidemiology. The prevention of congenital malformations is now possible. In fact, within this short period of time, congenital heart disease has become a community health problem in which the implications are clearly drawn.

Until recently, the armamentarium of the physician for treating rheumatic fever, forerunner of rheumatic heart disease, consisted principally of aspirin and the judicious application of bed rest. Today, prevention of streptococcus infection and of rheumatic fever by means of sulfadiazine and penicillin presents a sure fire method for controlling rheumatic fever and preventing rheumatic heart disease as a cause of death and disability. Furthermore, the perfection of surgical procedures for the relief of mitral stenosis and mitral regurgitation has assured many victims of chronic rheumatic heart disease of an increase in life expectancy and a decrease in the degree of their disability.

Hypertension remains a serious challenge. A small number of disease conditions associated with hypertension have already been split out of this large, ill-defined group and are amenable to treatment. The general recognition that essential hypertension is at the same time a psychiatric problem and a somatic disorder has brought us closer to the control of this syndrome. The causes of essential hypertension will not remain obscure, and methods of treatment and prevention of complications are already within reach. The outlook is encouraging.

While fundamental processes are still highly controversial, the relationship of altered fat metabolism and fat transport to the development of atherosclerosis is now unquestioned. The importance of diet, obesity and heredity as factors in causation requires further study. On the basis of experimental evidence, the long prevalent attitude that atherosclerosis is a physiologic process of aging has been rejected, and investigation of the population along sound epidemiologic lines is

a new order of business in the search for an answer to the problem of control of atherosclerosis. As in the case of hypertension, the responsibility for the control of these diseases rests as much with the official health agency as with the private physician and other community health resources.

National Heart Act

In the face of such remarkable advances in our knowledge of cardiovascular diseases, the high mortality rate and the staggering morbidity load assumed greater significance for the community than at any time during the past 25 years. It is understandable. therefore, why in 1948 George A. Smathers and others in the House of Representatives, and Senator Styles Bridges and others in the Senate, introduced similar bills calling for the enactment of what is now generally known as the National Heart Act, including the establishment of a National Heart Institute. Among other objectives. the purpose of these bills was to stimulate the local development of facilities for the prevention. diagnosis and treatment of cardiovascular disease and for the coordination of existing community resources to the same end. In a Senate hearing on this bill, Mr. Smathers submitted the following in urging passage of the Act: "The truth is that heart disease is at once the most serious and most neglected of all American health problems." For related reasons, the passage of this measure was strongly urged by representatives of the American Heart Association and the American Medical Association as well as by physicians, legislators and prominent lay persons. The most significant aspect of this bill is that it holds that the entire community is responsible for the development of effective measures for the control of heart disease at national, state and local levels.

Cooperative Efforts

With this information as a background, I should like to mention briefly some of the actions which are being taken in cooperation with local health groups. (1) In the field of education, the greatest emphasis is given to professional education for physicians, nurses, technicians, in fact, for all having anything to do with the prevention, diagnosis. treatment and rehabilitation of the person with cardiovascular disease.

(2) A survey of the state regarding the availability of diagnostic and treatment facilities for indigent persons with cardiac disease has been made, and it is an understatement to say that these facilities are entirely inadequate. The Florida State Board of Health, the Florida Heart Association and others should spare no effort in encouraging the creation of such facilities. Every health agency, whether official or voluntary, and every group or individual who might contribute to the organization of such facilities should be consulted and asked to assume a fair share of the responsibility. These two actions will reduce to a minimum the time lag between discovery and application of knowledge about cardiovascular disease.

(3) In the research field there is a critical need for studies including statistical surveys. While certain types of clinical and laboratory research may be beyond the scope of available facilities, we must not assume that all research must be carried out in communities with large medical centers and/or medical schools. Although other areas in the country possess advantages with respect to these, there is certainly no scarcity in Florida of physicians capable of performing intelligently planned and scientifically accurate research within our limitations. We should expand our activities in this field and with other agencies and organizations help to fill the big gaps in the knowledge needed for control of heart disease.

Time does not permit me to explore the possibilities which exist in all phases of the control program on a state or local level. I have given you the bare bones of the argument for directing a larger share of our attention to cardiovascular disease, and if I have accomplished nothing more than to convince you that cardiovascular disease is a community health problem and that we, as a community resource, have a responsibility in it, this will have been a most profitable 15 minutes.

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HOLLYWOOD BEACH HOTEL APRIL 25-28, 1954

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Oath of Hippocrates



I SWEAR by Apollo the Physician, and Aesculapius, and Hygeia, and Panacea, and all the gods and all the goddesses — and I make them my judges — that this mine oath and this my written engagement I will fulfil so far as power and discernment shall be mine.

HIM who taught me this art I will esteem even as I do my Parents; he shall partake of my livelihood and, if in want, shall share my goods. I will regard his issue as my brothers, and will teach them this art without fee or written engagement if they shall wish to learn it.

I WILL give instruction by precept, by discourse, and in all other ways, to my own sons, to those of him who taught me, to disciples bound by written engagement and sworn according to medical law, and to no other person.

SO FAR as power and discernment shall be mine, I will carry out regimen for the benefit of the sick, and will keep them from harm and wrong. To none will I give a deadly drug, even if solicited, nor offer counsel to such an end; likewise to no woman will I give a destructive suppository; but guiltless and hallowed will I keep my life and mine art. I will cut no one whatever for the stone, but will give way to those who work at this practice.

INTO whatsoever houses I shall enter I will go for the benefit of the sick, holding aloof from all voluntary wrong and corruption, including venereal acts upon the bodies of females and males whether free or slaves. Whatsoever in my practice or not in my practice I shall see or hear, amid the lives of men, which ought not to be noised abroad — as to this I will keep silence, holding such things unfitting to be spoken.

AND NOW if I shall fulfil this oath and break it not, may the fruits of life and of art be mine, may I be honored of all men for all time; the opposite, if I shall transgress and be foresworn.

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The Oath of Hippocrates

Renewed interest in the Oath of Hippocrates on the part of physicians is perhaps coupled in some instances with awakened interest on the part of the laity. Lay inquiries as to the nature of this declaration and requests from physicians for copies make this subject timely.

Understandably, today's followers of Aesculapius may have a somewhat nebulous concept of medicine's debt to Hippocrates, whom they know simply as the Father of Medicine. It was he who, in the fifth century before the Christian era, instigated the reform which for the first time separated medicine from religion. Prior to that time, the "hero-physician" Aesculapius, son of the divine Apollo, was revered as the God of healing, and as Greek medical treatment developed under religious control, the temples in which he was worshipped became sanatoriums for the care of the sick. The priests employed such practical therapy as rest and diet, but wisely assumed no responsibility. They held that the will of the gods determined the success or failure of their treatment, and the gods were capricious.

Relieving the gods of the responsibility for disease, Hippocrates placed it squarely upon the shoulders of man. Forthwith, man's condition became man's problem, for which man himself must find the solution. The will of the gods no longer served to cover his ignorance. From that day to this, the history of medicine is the record of the extent of man's acceptance of this responsibility.

This first and greatest of all physicians formulated certain principles of science which became the foundation stones of modern medicine. They have been summarized as: (1) There is no authority except facts; (2) Facts are obtained by accurate observation, and (3) Deductions are to be made only from facts. Opposed to dogma and mere opinion, this familiar aphorism of Hippocrates has become a part of the literature of all lands: "Life is short and art is long, the occasion fleeting, experience fallacious and judgment difficult."

Hippocrates lived in the age of Pericles, the Golden Age of Greece, when the highest achievements of Greek intellect in art, literature, government and science were attained. He was a contemporary of Plato and Aristotle. Plato mentioned him as if he were a living man known to him, and Aristotle was deeply influenced by him. In him countless generations of physicians have found a model of nobleness of professional character. With the Oath which bears his name, he founded an ethical code which is in principle as applicable to the ethics of the physician today as it was 2,500 years ago. The Journal is pleased to reproduce the Oath in this issue.[1]

The name of Hippocrates remains across the centuries synonymous in medicine with the highest idealism and ethical conduct. It was, however, by

wresting the art of healing from the gods and making it man's that this early Greek physician won his place as one of the great human liberators. Breaking sharply with superstition, he looked upon disease as part of the order of nature, having a natural cause and a certain course which could be studied, recorded, and perhaps even predicted and altered. In so doing he became the first to emerge, as Osler said, "out of the murky night of the East, heavy with phantoms, into the bright daylight of the West."

1. Other versions of the Oath may be found in Dorland's American Illustrated Medical Dictionary, ed. 22, 1951, page 681, the New Gould Medical Dictionary, ed. 1, 1949, page 465, and the Journal of the American Medical Association, Oct. 24, 1953, page 733.

No Need for Doctor Draft After 1955

Under present plans, the Defense Department expects no extension of the doctor draft beyond July 1, 1955. Instead, the program calls for "fence mending" and "belt tightening," so federal officials concerned with the law told the Association of Military Surgeons at their annual meeting.[1]

Dr. Melvin A. Casberg, Assistant Secretary of Defense for health and medical affairs, said steps are being taken or planned to stimulate regular medical officer procurement, which include study of a law to provide medical scholarships to students commissioned in the Armed Forces following graduation. He added that it is the duty of civilian organizations to aid the military in procuring more experienced doctors for teaching and training posts in the services.

A further reduction in the physician-troop ratio, from a projected 3.2 to 2.9, was recommended by Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee, as one form of belt tightening. In his opinion, it should be possible to meet requirements after mid-1955 from each year's graduating classes if the size of the Armed Forces does not increase. Meanwhile, however, the drafting of doctors will be resumed late next summer or early fall, he said, and it is possible that as many as 1,250 Priority III doctors in their early thirties will have to be called during the life of the act.

In his address to the association, Dr. Edward J. McCormick, the president of the American Medical Association, referred to extension of the doctor draft beyond July 1955 in these words: "It is our belief that this is a most propitious time for devising a program which will clearly eliminate any need for this legislation well in advance of July 1, 1955." He also stated that (1) the problem of medical care for military dependents should be turned over for study to the Hoover Commission on government reorganization, with final determinations by the Congress, (2) meanwhile, there should be improved utilization of military medical personnel and curtailment in nonprofessional duties, and (3) in the event a universal military training program is voted, then preprofessional and professional education for qualified students should be continued.

Certainly every effort should be made to devise a satisfactory program for regular medical officer procurement which will eliminate further draft legislation.

1. The AMA Washington Letter, No. 46, Nov. 13, 1953.

Watch the Omniscient Planner

The American physician no longer can afford to be indifferent to social security plans anywhere at any time. These plans the world over are constantly being expanded to include all kinds of medical care provisions, and their future is of primary concern to him.

This medical frankenstein of the future was recognized in its true proportions by the World Medical Association at its 1953 meeting in The Hague. This organization, representing physicians from 46 nations, strongly opposed medical care under government-controlled social security schemes, on the ground that forcing a physician to work on a full time salaried medical service under a government plan would rob him of all incentive.

"The only incentive in socialism is to socialists" was the editorial comment in one newspaper which applauded the World Medical Association's position. "If an industry is nationalized," this lay source continued, "it and its workers and managers are put at the service of the socialists in government. If medicine is socialized, the benefit to the doctors and the patients will be less. But the benefit to the burocrat is tremendous.

"If there then should be something less than enthusiasm among the younger generation for entering the medical profession, the burocrat will rectify that by subsidizing the medical education of aspirants with the right political references. And that gives him a hold on something else — education. Once started, the thing snowballs, and if no one else is particularly happy, the omniscient planner is sure to be."

Keep an eye on the expanding worldwide social security plans, Doctor. Remember — they snowball. The future of the profession is at stake.

State Money Versus Federal Money Reversal of Trend Advocated

In the opinion of the Secretary of Health, Education, and Welfare, the time has come to reverse the trend and use more state money and less federal money in vocational rehabilitation work. When the program started in 1921, she noted, the federal share was only one third; in 1947, federal contributions reached a peak of 73.5 per cent, and for the current fiscal year declined somewhat to approximately two thirds. Mrs. Hobby told the National Rehabilitation Conference in October that appropriations committees in the Congress already had begun to "question the wisdom of providing such a proportion of federal funds for a program keyed to the principle of state operations . . . To me it is simply additional evidence that the time has come to review and inventory our programs."

The Secretary added that her department "plans to propose legislation to strengthen administration of the program and to permit new approaches to old problems, without disrupting the important work which the state agencies are carrying on daily." She thought the Manion Commission, currently studying U. S.-state relations, would look into such programs as vocational rehabilitation. It was her belief that the commission "offers a promise for a healthy re-examination of federal, state and local governmental interrelations, and I think we must all welcome their efforts to clarify the roles of each."

Undersecretary Nelson Rockefeller, second only to Mrs. Hobby in the Department of Health, Education, and Welfare, addressed state and territorial health officers at their annual conference in November. He assured them that grants to health activities will continue, adding that the issue is how a given function "can best be performed and supported." He pointed out that (1) in the poorest states with the greatest health needs, the nation as a whole has a responsibility, (2) the government should provide special aid to unique projects such as migratory labor groups, (3) technical and professional aid to states will be continued, and (4) the federal-state partnership should have the motto: "Maximum opportunity for state decision and minimum federal control."

This motto is timely. A clarification and a restoration of proper balance in the sphere of federal, state and local interrelationships would indeed be most welcome.

American Medical Education Foundation Progress

Early in December at the St. Louis session of the American Medical Association, a fourth grant of $500,000 was made by the American Medical Association to the American Medical Education Foundation for financial aid to the nation's hard-pressed medical schools. At that time the 1953 income of the foundation totaled $1,174,000, and the number of contributors was more than double the total in 1952.

New officers of the foundation elected at that meeting were: president, Dr. Louis H. Bauer, secretary-general of the World Medical Association and immediate past president of the American Medical Association; vice president, Dr. George F. Lull, secretary and general manager of the American Medical Association; and secretary-treasurer, Dr. Edward L. Turner, secretary of the A.M.A. Council on Medical Education and Hospitals. Dr. Bauer succeeds the late Dr. Elmer L. Henderson of Louisville, Ky., also a recent past president of the American Medical Association.

The foundation, established in 1950, solicits voluntary contributions from the medical profession to relieve the financial strain under which the medical schools of the country operate. Dr. Bauer stated that the medical colleges need approximately $10,000,000 annually to meet the increasing costs of operation. The foundation has raised approximately $2,700,000 from physicians alone. It operates in cooperation with the National Fund for Medical Education, and the two organizations have received contributions of nearly $5,100,000 during the last three years.

The St. Louis Globe-Democrat carried a strong article on the work of the foundation and also published an editorial commending the American Medical Association for carrying out this prodigious task, which continues to meet with increasing success. It also commended the physicians for accomplishing this undertaking themselves instead of turning to Washington for financial assistance.

The Editor Invites Your Contributions on Data of Notable Interest

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St. Louis A.M.A. Clinical Session

The total registration of 7,716 at the Seventh Annual Clinical Session of the American Medical Association, held early last December in St. Louis, exceeded that of the midwinter meeting there in 1948 by 2,255. The 2,730 physicians present numbered 530 more than at the meeting five years before. This evidence of wide and increasing interest is indicative of what may be expected when the Clinical Session this year is held in Miami, November 30 to December 3.

As outlined in Briefs, Number 86, Dec. 9, 1953, and reported comprehensively in recent issues of the Journal of the American Medical Association, the House of Delegates took important action on matters pertaining to social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, and military affairs. Also given consideration were the supply of interns, the commission on intergovernmental relations, the scope of the word "rehabilitation," rural health, hospital-physician relations, simplification of membership classifications, and the training of chiropractors and naturopaths.

A few highlights of addresses made at the meeting keynote issues of the day. President Edward J. McCormick of Toledo, Ohio, reviewing observations made during his first six months in office, warned at the opening session of the House of Delegates that there has been little change in the federal government's trend toward socialism. He also cited a need for better methods of communicating medicoeconomic problems to the individual physician and called on other professions and vocations to clean their own houses.

Expressing opposition to a campaign of national publicity that would heap upon "the great percentage of honest physicians . . . the sins of the few," Dr. McCormick appealed for "action that will further full confidence of the public in our profession." He added:

"Good public opinion cannot be bought. It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A.M.A. and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures.

"Doctors must know more of public thinking regarding fees and physician-patient relationship if we are to continue to exist as free scientists and practitioners.

"We have a policing job to do, and it must be done through the medium of existing disciplinary machinery. It cannot be done in any other way."

Speaker James R. Reuling of Bayside, N. Y., called on physicians to be missionaries in matters of medical concern. Observing that "times are just as troubled as when we had blanket bills before Congress which would have socialized the practice of medicine," he declared, "If we are to be effective, each and every one of us must be a missionary in his own community and in his own state to carry back to the grass roots the story, the problems, and the possible solutions to the problems, not only in improving the health and care of our citizens but also to protect them from the do-gooders."

One of several guest speakers, Dr. Chester Keefer of Boston, special assistant to Mrs. Oveta Culp Hobby, Secretary of the Department of Health, Education, and Welfare, urged maximum effort, cooperation and leadership on the community level. "The voluntary way has been the most successful in the past," he said, "and there is no reason to believe it will not continue to be in the future."

The scientific program was geared to the general practitioner and his practical clinical problems, but the many excellent papers and exhibits had broad appeal for specialists as well. They were of the usual high caliber.

Dr. Reuben B. Chrisman, Jr., of Miami became a member of the Committee on Legislation at this meeting. He also served on the Reference Committee on Executive Session. Dr. Louis M. Orr of Orlando is a member of the Council on Medical Service and chairman of the Council's Committee on Federal Medical Services. Dr. Homer L. Pearson, Jr., serves on the Judicial Council.

Dr. Pearson has been appointed general chairman in charge of local arrangements for this year's clinical meeting, which convenes in Miami on the last day of November. Plans have long been under way for this Eighth Annual Clinical Session to be held in the large Dinner Key auditorium. The many Florida physicians who plan to attend should be mindful of the wide interest already being manifested in this meeting and should make reservations early.

Southern Physicians Honored

The recipient of the 1953 General Practitioner's Award was Dr. Joseph I. Greenwell of New Haven, Ky. This selection of the "General Practitioner of the Year" by a special committee of the Board of Trustees of the American Medical Association was announced on December 1 at the Clinical Meeting in St. Louis. Dr. Greenwell, at the age of 80, becomes the seventh family doctor to be added in this way to the roster of truly outstanding general practitioners.

Less than 20 miles from the birthplace of Abraham Lincoln, Dr. Greenwell has maintained an office for 53 years, practicing in four Kentucky counties. During much of that time he has performed his professional duties under conditions almost as primitive as those which prevailed when Lincoln was born. Since he received his M.D. degree from the Louisville Hospital College of Medicine in 1900, he has delivered nearly 4,300 babies, more than 80 of them during 1953, whether in log cabin or Bardstown's modern hospital. He has answered calls on foot, by rowboat, by horse and buggy, and even by switch engine, as well as by automobile.

An Alabama doctor also was signally honored in St. Louis, just prior to the Clinical Meeting. Dr. James Somerville McLester of Birmingham, a practicing physician for more than 50 years, received the Joseph Goldberger award for outstanding contributions in the field of clinical nutrition. Presented by the Board of Trustees of the American Medical Association through its Council on Foods and Nutrition, this annual award includes a gold medal and $1,000. Dr. McLester's role in translating the results of nutrition research into human values and in the integration of nutrition into the teaching of all phases of medicine won for him this high honor. This distinguished physician is a past president of the American Medical Association and has served as chairman of its Council on Foods and Nutrition. His book entitled "Nutrition and Diet in Health and Disease" is widely used in the teaching of nutrition. Dr. McLester is professor emeritus of medicine at the Medical College of Alabama.

Hundredth Birthday Celebration of Duval County Medical Society

Antedating other medical societies in Florida by two decades, the Duval County Medical Society became 100 years old in 1953. The centennial year was celebrated at a banquet on December 16 in the George Washington Hotel in Jacksonville. Presiding was Dr. Karl B. Hanson, the society's president, and serving as master of ceremonies was Dr. Webster Merritt, the chairman of the celebration committee.

U. S. Senator George A. Smathers was the guest speaker. In his address he discussed problems of paramount interest to the medical profession and warned that those who would shackle the profession to socialism, while seemingly quiet, are merely adopting new insidious approaches to that end.

In addition to a large representation of the members and their wives, guests were present from Bunnell, DeLand, Gainesville, Lake City, Miami, Ocala, St. Augustine, St. Petersburg and Tallahassee. Dr. Duncan T. McEwan of Orlando, President-Elect of the Florida Medical Association, represented that organization. The oldest living past president of the Florida Medical Association, Dr. William E. Ross of Jacksonville, was given special recognition.

Members of the society recognized by the master of ceremonies were Dr. Wm. S. Manning and Dr. Lester W. Cunningham, who had practiced medicine 50 and 48 years respectively in Jacksonville, and all past presidents who were present. Special recognition was accorded Mrs. Samuel S. Lombardo as president of the Ladies Auxiliary to the Duval County Medical Society, and all past presidents in attendance were given recognition. Mrs. Frederick J. Waas was thanked for arranging the beautiful decorations.

In commemoration of its founding on May 25, 1853, the society planned, in addition to the banquet, a pictorial book of 140 pages containing some 300 illustrations. Tear sheets of the book, edited by Dr. Merritt, with Dr. Joseph J. Lowenthal as associate editor, were exhibited at the banquet. The book was expected to be off the press early in 1954. It covers the history of medicine and related events marking the development of the Jacksonville area and contains many little known historical facts.

It was during the presidency of Dr. W. W. Rogers, the immediate past president of the society, that plans for the 100th Birthday Celebration were perfected. Serving on the centennial committee appointed by Dr. Rogers were: Dr. Merritt, J. Kenneth Attwood, Dr. J. Lunsford Boone, Dr. Hanson, Dr. Robert B. McIver, Dr. Edward Jelks, William S. Johnson, Fred H. Kent, Dr. Raymond R. Killinger, Dr. Lowenthal, Dr. Shaler Richardson, Dr. John T. Stage, Dr. Sidney Stillman, Dr. H. Marshall Taylor, Dr. Frederick J. Waas and Olin E. Watts. The four distinguished lay members gave the committee invaluable assistance; they were accorded special recognition and commendation for their services. Dr. McIver also deserves high praise for his part in making the banquet a most delightful occasion.

The Warning Shadow

Because of the recent disturbing and rather abrupt increase in cancer of the lung, the American Cancer Society and the National Cancer Institute have jointly produced a 16 mm. sound motion picture, "The Warning Shadow," to help the medical profession teach men the same lesson learned by women from the national award-winning film, "Breast Self-Examination." That lesson: Cancer can often be cured when detected early.

The new film mirrors the trend revealed in statistics of the last several years which show that the incidence of cancer in general as well as the death rate is definitely and progressively rising in men, that is, in the 20 years since the first cure of pulmonary malignant disease made medical history, cancer of the lung in men over 45 years of age has increased more than 200 per cent.

This latest film in the continuing fight to dispel the shadows of cancer tells the story of the first cure of cancer of the lung. "The Warning Shadow" re-enacts the historic operation of Dr. Evarts A. Graham which cured Dr. James L. Gilmore in April 1933. Both doctors, who are still practicing medicine, discuss the operation in the film.

As science extends the useful length of life, adding active years to the mid-ages when men have the experience and energy to contribute most to their communities, the menace of cancer of the lung to men over 45 is multiplying. Even though cancer of the lung can be cured, only one man out of every 20 now stricken is cured.

This ratio remains a blight on humanity partly because it is not generally known that men apparently in good health may have early cancer of the lung which can be diagnosed by roentgen examination considerably before the appearance of symptoms — and when the cancer is curable. This new film, which has been approved by the Florida Cancer Council, is now available and has already been used in some sections of the state. It makes clear that periodic roentgen examinations every six to 12 months for men over 45 are necessary insurance against the ever increasing death threat of cancer of the lung.

With this film, the American Cancer Society in cooperation with the Florida Medical Association and the Florida State Board of Health hopes to save many men, as Dr. Gilmore was saved, in the prime of their lives when they are most valuable to their families and communities.

While the film was produced for showing to the lay public, it is recommended that all physicians preview it prior to a public showing in any county.

It could well be a part of a county medical society meeting program and can be obtained through county units of the American Cancer Society; the Florida Division Office of the Society, 617 Flagler Building, Tampa; or from the Florida State Board of Health at Jacksonville.

Salute to Vicksburg Physicians

In the wake of a devastating tornado, which left scores dead and hundreds injured in Vicksburg, Miss., during the recent preholiday season, the physicians of that city wrote a warm and memorable chapter in its book of sorrows. They worked unceasingly to care for the injured despite great handicaps, since both electric power and natural gas services were interrupted by the storm.

Fortunately, the city's four hospitals, with a total bed capacity of about 400, were undamaged. As Vicksburg is a medical center, normal bed occupancy in these hospitals averages 75 per cent, or more than 300 patients. Nevertheless, more than 250 injured persons requiring hospital treatment almost immediately after the storm received outstanding and praiseworthy service for which the physicians and hospitals earned high commendation.

Some 40 doctors, members of the Issaquena-Sharkey-Warren Counties Medical Society, voted unanimously to give without charge all professional services rendered after the storm. Their action was all the more significant in view of the $100.000 emergency relief fund voted immediately by the Mississippi legislature, about $75,000 expended by the National Guard, Civil Defense emergency funds authorized at once by President Eisenhower by telephone from Bermuda, and Red Cross funds and personnel promptly made available.

The position of the Vicksburg doctors in declining payment for services from private patients and the several emergency funds won much favorable publicity, as did their efficient handling of disaster operations. The newspapers applauded both their decorum and their skill, as did medical circles throughout the state. Like the physicians of Waco, Texas, who met a similar disaster in like manner some months earlier, they proved their preparedness to cope with emergencies and gave of their strength, skill and time unstintingly. While public recognition of their unselfish service is gratifying and appropriately strengthens the doctor-patient relationship, physicians would be the last to expect or seek such acclaim. It may also be said that their everyday role of coping with emergencies and potential emergencies too often is taken for granted and seldom fully appreciated.

Southeastern Surgical Congress Birmingham Assembly March 8 - 11, 1954

The Twenty-Second Annual Assembly of the Southeastern Surgical Congress will convene at the Dinkler-Tutwiler Hotel in Birmingham, Ala., on Monday, March 8, and will continue through Thursday, March 11.

A notable feature of the scientific program is a panel discussion each day from 4:30 to 5:30 p.m., except Thursday, when the hours are 12:30 to 1:30 p.m. The subjects for discussion are "Traumatic Lesions," "Esophagogastrointestinal Hemorrhage," "Liver and Gallbladder Pathology," and "Surgical Management of Peptic Ulcer," and they will be presented in the order named.

The distinguished guests who will participate in the comprehensive program are: Drs. W. A. Altemeier, Cincinnati; R. Russell Best, Omaha; B. Marden Black, Rochester, Minn.; David P. Boyd, Boston; Alexander Brunschwig, New York; A. R. Curreri, Madison, Wis.; Michael E. De Bakey, Houston, Texas; J. Englebert Dunphy, Boston; Jack M. Farris, Los Angeles; Merrill N. Foote, Brooklyn; Louis G. Herrmann, Cincinnati; William D. Holden, Cleveland; Claud J. Hunt, Kansas City; Julian Johnson, Philadelphia; Conrad R. Lam, Detroit; John C. McClintock, Albany, N. Y.; Raymond W. McNealy, Chicago; Michael L. Mason, Chicago; John R. Paine, Buffalo; Henry K. Ransom, Ann Arbor, Mich.; Harris B. Shumacker, Jr., Indianapolis; Waltman Walters, Rochester, Minn.; Kenneth W. Warren, Boston; and M. M. Zinninger, Cincinnati.

Florida physicians will present three of the twenty-eight papers scheduled for presentation by members of the Congress. Dr. Thad Moseley of Jacksonville will present a paper on "The Surgical Treatment of Gastrojejunocolic Fistula." The title of the paper to be presented by Dr. Wade C. Myers, Jr., of Tampa is "A Review of Presacral Tumors and a Report of a Case of Presacral Dermoid." Drs. Louis M. Orr, James L. Campbell and Miles W. Thomley of Orlando are scheduled to present a paper entitled "Radio Active Isotopes in the Treatment of Cancer of the Prostate." Dr. Julius C. Davis of Quincy is the Florida Councilor to the Southeastern Surgical Congress.

STATE BOARD OF HEALTH

State Board of Health Equipped to Measure Radiation

Recently the Florida State Board of Health was asked to search for two radium needles that had been mislaid somewhere in a physician's office suite.

When taken into the office laboratory the Geiger instrument indicated the presence of considerable radioactivity in one corner of the room. However, the extreme sensitivity of this instrument prevented definite localization of the radioactive source.

An ionization chamber was then brought into use and it was found that the radiation was coming from an adjoining treatment room. The missing needles were quickly found in a radium applicator. Evidently the needles had not been returned after use to the lead container in which they are normally stored.

A routine check was made to measure stray radiation when the lead container was located in the safe. In spite of the lead shielding it was found that radiation was being emitted in quantities sufficient to create a potential hazard at the outer surface of the safe. A recommendation was made to provide lead sheets sufficient to reduce the radiation to levels acceptable in present day practice.

Although this may be an isolated instance it calls attention to the real need for proper shielding of radioactive material. The Florida State Board of Health is equipped to measure radiation from all radioactive sources including x-rays, free of charge on request from physicians. It is hoped that all physicians using any form of radioactivity for diagnostic or therapeutic uses will feel free to call for this service.

DEATHS

Deaths — Members

English, Alvin Q., Palmetto	Dec. 4, 1953
MacDonell, Geo. N., Miami	Dec. 8, 1953
Griffin, James C., Tampa	Dec. 13, 1953
Smith, Samuel F., Lakeland	Dec. 14, 1953

Deaths — Other Doctors

Burgner, Benjamin H., Chicago	Oct. 15, 1953
Shipley, John T., Palm Beach	Oct. 26, 1953

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Campbell, Francis J., Miami
Handwerker, John V., Miami
Kish, Alex, Live Oak
Richardson, William W., Graceville
Waugh, William C., Dunnellon

STATE NEWS ITEMS

Drs. Thomas H. Bates and Louis G. Landrum of Lake City have been elected to the Board of Directors of the Lake City-Columbia County Chamber of Commerce for 1954.

Dr. Edward Jelks of Jacksonville was guest speaker at a meeting of the Woman's Auxiliary to the Duval County Medical Society on November 24. He spoke on "Public Relations in the Field of Medicine."

Dr. Walter R. Newbern of West Palm Beach has been elected chairman of the Palm Beach County Unit of the American Cancer Society. Dr. Willard F. Ande of West Palm Beach is vice chairman.

Dr. Sherman B. Forbes of Tampa spoke on the structure and function of the eye as related to light at a dinner meeting of the Florida Chapter of the Illuminating Engineering Society of America in December.

Dr. Richard C. Cummings of Ocala has been elected mayor of that city.

President Frederick K. Herpel of West Palm Beach gave the welcoming address at the two-day meeting of the Southeastern Section of the International College of Surgeons in that city on January 29 and 30. Dr. Lloyd J. Netto of West Palm Beach was chairman of the local committee on arrangements, and presided at the opening session. Dr. Raymond S. Roy, also of West Palm Beach, presided at the Saturday morning session.

Drs. Milton M. Coplan and Frank M. Woods of Miami presented papers at the November meeting of the Cuban Urological Society in Havana. They were elected honorary members of the Association. Dr. Coplan represented the American Urological Association.

Drs. Theodore M. Berman of Miami Beach and Oliver P. Winslow Jr. of Miami recently completed an intensive short course in radiation therapy at the Continuation Study Center of the University of Minnesota, Minneapolis.

Dr. Maurice I. Edelman of Miami Beach has returned to his practice after receiving training in surgical planing of the skin for treatment of acne scars and other skin defects under the supervision of Dr. Abner Kurtin in New York City.

The fourth midyear meeting of the Florida Obstetric and Gynecologic Society was held at the Orange Court Hotel in Orlando in December. Several talks and panel discussions were held as well as a social hour and dinner in the evening.

Dr. Wm. E. Van Landingham of West Palm Beach, city physician for 30 years, was awarded the Civitan's Outstanding Services Award for 1953 at a luncheon on December 3.

Dr. Edward W. Ford of Crescent City has been practicing medicine in rural communities for 62 years. Dr. Ford, who is now 86 years old, has been practicing in Crescent City for 34 years.

Dr. Robert T. Spicer of Miami has been named Dean of the University of Miami School of Medicine. Dr. Spicer is the first person to hold the title of Dean; Dr. Homer Floyd Marsh has been Acting Dean since the School opened nearly two years ago.

Drs. Alvin L. Stebbins and Herbert L. Bryans of Pensacola congratulated 10 students of the Pensacola Vocational School who recently completed a 12-month training course in practical nursing. Dr. Stebbins, then president of the Escambia County Medical Society, represented the Society at the exercises.

Officers of the Greater Miami Eye, Ear, Nose and Throat society for 1954 are Dr. George E. McKenzie of Miami, president; Dr. Maurice I. Edelman of Miami Beach, vice president; and Dr. James H. Mendel Jr. of South Miami, secretary-treasurer.

Members of the Florida Medical Association who attended the A. M. A. Clinical Session in St. Louis, December 1-4 were: Drs. Homer L. Pearson Jr., Herbert W. Virgin Jr., Reuben B. Chrisman Jr. and E. Sterling Nichol, all of Miami; and Drs. Louis M. Orr of Orlando, and Louis J. Polskin of Lakeland. Dr. Nichol presented a paper at the meeting.

Dr. Carlos P. Lamar of Miami met with a group of leaders of the Pan American Medical Association in Washington, D. C. in December.

Dr. Cleland D. Cochrane of Daytona Beach attended the meeting of the Academy of Obstetrics and Gynecology in Cincinnati in December.

Dr. H. Phillip Hampton of Tampa spoke on "The Diabetic Faces Facts" before the Lay Diabetic Society of St. Petersburg in December.

Dr. George F. Schmitt Jr. of Miami was recently certified as a Registered Parliamentarian by the National Association of Parliamentarians. The Journal knows of no other physician in the United States who is so certified.

Dr. Vernon T. Grizzard Jr. of Jacksonville attended the annual meeting of the Congress of Neurological Surgeons in New Orleans in November.

Dr. Henry E. Branca of Fort Pierce spoke on the care of the eyes at a noon meeting of the Fort Pierce Lions Club in December.

Dr. William L. Wright of Sarasota was moderator of a symposium on "General Aspects of Mental Health in Medical Practice," at a meeting of the Mental Health Society in Sarasota in December. Drs. Henry G. Morton, Thomas R. Young Jr. and Edward M. Langer of Sarasota took part in the program, which was planned by Dr. Cecil E. Miller, also of Sarasota.

Dr. Joseph H. Lucinian of Miami recently attended the meeting of the Pan American Medical Association at Caracas, Venezuela, and Havana, Cuba.

Dr. Lawrence H. Kingsbury of Orlando spoke on some aspects of chest surgery at the January meeting of the Lake County Medical Society.

The Southeastern Allergy Association will hold its annual meeting at the Dinkler-Plaza Hotel, Atlanta, Ga., March 25-27, 1954. For more detailed information, write Katharine B. McInnis, M.D., secretary, 1515 Bull St., Columbia, S. C.

COMPONENT SOCIETY NOTES

Alachua

New officers of the Alachua County Medical Society are Drs. Henry H. Graham, president; Edwin H. Andrews, president-elect; Frank M. Hall, vice president; and Glenn O. Summerlin, secretary-treasurer, all of Gainesville.

Bay

At the regular monthly meeting of the Bay County Medical Society, officers for 1954 were elected as follows: Dr. Lemuel F. Coxe Jr., president; Dr. William F. Humphreys Jr., vice president; Dr. James M. Nixon, secretary; and Dr. John J. Benton, treasurer, all of Panama City.

Brevard

Officers elected to serve the Brevard County Medical Society in 1954 are Drs. Theodore J. Kaminski, president, Melbourne; Lee Rogers Jr., vice president, Cocoa; and Paul L. Summers, secretary-treasurer, Melbourne.

Broward

Dr. Julius F. Boettner of Fort Lauderdale was installed as president of the Broward County Medical Association for 1954. Dr. Ernest E. Serrano of Hollywood has been elected president-elect; Dr. Albert A. Parrish of Fort Lauderdale, vice president; and Dr. George T. F. Rahilly of Fort Lauderdale, secretary. Re-elected treasurer was Dr. W. Dotson Wells of Fort Lauderdale.

Columbia

Dr. Robert B. Harkness of Lake City was re-elected president of the Columbia County Medical Society for 1954. Also re-elected were Dr. Laurie J. Arnold Jr., vice president, and Dr. Thomas H. Bates, secretary-treasurer, both of Lake City.

Dade

Dr. Edward W. Cullipher of Miami will serve as president of the Dade County Medical Association in 1954. Other officers elected at the regular December meeting include: Drs. L. Washington Dowlen, president-elect; Hunter B. Rogers, vice president; and Kenneth S. Whitmer, secretary, all of Miami; and Robert P. Keiser, treasurer, of Coral Gables.

At the regular January meeting of the Association, Dr. Morris H. Blau spoke on "Difficulties Encountered in the Diagnosis of Biliary Tree Disease." The paper was discussed by Drs. Walter C. Jones, Donald W. Smith and Martin S. Belle.

DeSoto-Hardee-Highlands-Glades

The new officers of the DeSoto-Hardee-Highlands-Glades County Medical Society are Dr. Carl J. Larsen of Avon Park, president, and Dr. Samuel A. King of Avon Park, secretary-treasurer.

Duval

At the regular meeting of the Duval County Medical Society in December, Dr. Karl B. Hanson of Jacksonville was installed as president. Officers elected at the meeting include Drs. Thomas H. Lipscomb, vice president; Jackson L. Allgood Jr., secretary; and Sidney Stillman, treasurer, all of Jacksonville.

The January meeting of the Society was held on January 5 at the U. S. Naval Hospital, Naval Air Station, Jacksonville. Lt. C. A. Mead spoke on "Diagnosis of Abnormalities of Gait."

(Continued on page 572)

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

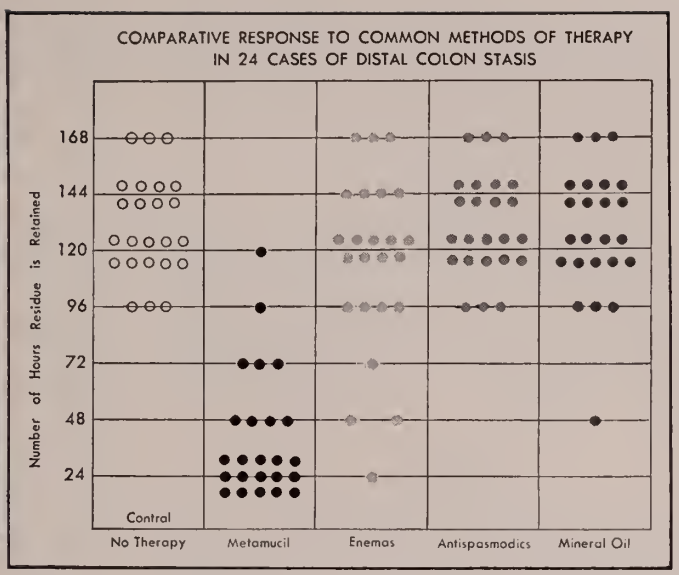
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SEARLE *Research in the Service of Medicine*

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. Rev. Gastroenterol. *19*:154 (Feb.) 1952.

(Continued from page 570)

Escambia

At a meeting of the Escambia County Medical Society on December 8, the following officers were elected for 1954: Drs. Wilton E. Tugwell, president; George W. Morse, president-elect; Joseph L. Rubel, vice president; and Paul F. Baranco, secretary-treasurer, all of Pensacola.

Franklin-Gulf

At the annual meeting of the Franklin-Gulf County Medical Society on December 9, Dr. Albert L. Ward of Port St. Joe was elected president of the Society for 1954. Also elected were Drs. Harold B. Canning of Wewahitchka, vice president, and Warren T. Weathington of Apalachicola, secretary.

Hillsborough

At the meeting of the Hillsborough County Medical Association on December 1, Dr. C. Frank Chunn of Tampa was installed as president for the coming year. Other officers elected at the meeting were Drs. Frank S. Adamo, president-elect; Wesley W. Wilson, vice president; and Arthur J. Wallace, treasurer. Re-elected to office was Dr. Julien C. Pate Jr., secretary. All of these officers are from Tampa.

At the regular January meeting of the Association, Dr. Eugene B. Maxwell was in charge of a program on "Welfare Work in Hillsborough County." Mr. Ernest Gibson, acting managing director of the Florida Medical Association, was a guest speaker.

Indian River

New officers of the Indian River County Medical Society are Drs. William L. Fitts 3rd, president; Erasmus B. Hardee, vice president; and Vernon L. Fromang, secretary-treasurer, all of Vero Beach.

Jackson-Calhoun

Officers of the Jackson-Calhoun County Medical Society for 1954 are Drs. Jabe A. Breland, president; Richard H. Schulz, vice president; and Francis M. Watson, secretary-treasurer, all of Marianna.

Lake

The list of officers who will serve the Lake County Medical Society during 1954 appeared in the December 1953 Journal.

At the regular meeting of the Lake County Medical Society on January 6, Dr. Lawrence H. Kingsbury of Orlando spoke on "Chest Surgery."

Lee-Charlotte-Collier-Hendry

The newly-elected officers of the Lee-Charlotte-Collier-Hendry County Medical Society are Drs. H. Quillian Jones, president, and James L. Bradley, secretary-treasurer. Re-elected vice president was Dr. Curtis R. House. All of these officers are from Fort Myers.

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Leon-Gadsden-Liberty-Wakulla-Jefferson

Officers of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society for 1954 are Drs. George H. Massey, president, of Quincy; William L. Hunter, vice president, of Monticello; and Odis G. Kendricks Jr., secretary-treasurer, of Tallahassee.

Madison

New officers of the Madison County Medical Society are Drs. Wallace E. Winter, president, and Julian M. DuRant, secretary, both of Madison.

Manatee

Dr. Willett E. Wentzel of Bradenton is the new president of the Manatee County Medical Society. Vice president of the Society is Dr. Harvey C. Pauley Jr., and secretary-treasurer is Dr. Marjorie L. Warner, both of Bradenton.

Marion

At the regular meeting of the Marion County Medical Society on December 15, Dr. William H. Anderson of Ocala was elected president for 1954. Dr. John P. Moore of Ocala was elected vice president, and Dr. Bertrand F. Drake of Dunnellon was re-elected secretary-treasurer.

Monroe

Officers of the Monroe County Medical Society for 1954 are Drs. Edward Gonzalez, president; Ralph Herz, vice president; and Herman K. Moore, secretary-treasurer, all of Key West.

Nassau

Dr. David G. Humphreys was re-elected president of the Nassau County Medical Society for 1954. Also re-elected were Dr. Benjamin F. Dickens, vice president, and Dr. John W. McClane, secretary-treasurer. All three officers are from Fernandina.

Orange

The newly-elected officers of the Orange County Medical Society are Drs. Eugene L. Jewett, president; Don C. Robertson, president-elect; Elwyn Evans, vice president; and Thomas R. Collins, treasurer. Re-elected to office was Dr. Andrew W. Townes Jr., secretary. All of these officers are from Orlando.

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Palm Beach

Dr. Thomas E. Daly of West Palm Beach is the newly-installed president of the Palm Beach County Medical Society. Dr. Edwin W. Brown of West Palm Beach was elected president-elect, and Dr. Oscar L. Kelley of Palm Beach was elected vice president. Re-elected were Dr. David A. Newman of West Palm Beach, secretary, and Dr. Russell D. D. Hoover of Palm Beach, treasurer.

Pasco-Hernando-Citrus

Officers of the Pasco-Hernando-Citrus County Medical Society for 1954 are Drs. Frank Y. Robson, New Port Richey, president; Gail M. Osterhout, Inverness, vice president; S. Carnes Harvard, Brooksville, vice president; and W. Wardlaw Jones, Dade City, secretary-treasurer.

Pinellas

The list of officers who will serve the Pinellas County Medical Society during 1954 appeared in the December 1953 Journal.

At the regular monthly meeting on January 4, Mr. Lee Ballard, vice chairman of the State Board of Control, and Mr. Ernest Gibson, acting managing director of the Association, were guest speakers.

Polk

Dr. Theodore C. Keramidas of Winter Haven was elected president of the Polk County Medical Association for 1954. Dr. John P. Tomlinson Jr. of Lake Wales is the new vice president. Dr. James T. Shelden of Lakeland was re-elected secretary-treasurer.

Putnam

Dr. Lawrence G. Hebel of Palatka was elected president of the Putnam County Medical Society for the coming year. Re-elected secretary-treasurer was Dr. James A. Long Jr. of Palatka.

St. Johns

President of the St. Johns County Medical Society for 1954 is Dr. James J. DeVito of St.

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Augustine. Re-elected were Drs. George C. Hopkins, vice president, and Reddin Britt, treasurer. Dr. Reuben J. Plant Jr. is secretary. All are from St. Augustine.

St. Lucie-Okeechobee-Martin

Dr. Laurence D. Van Tilborg is the new president of the St. Lucie-Okeechobee-Martin County Medical Society, and Dr. Henry E. Branca is the vice president. Both are from Fort Pierce. Re-elected secretary-treasurer of the Society for 1954 was Dr. Adrian M. Sample, also of Fort Pierce.

Sarasota

New officers of the Sarasota County Medical Society are Drs. Henry J. Vomacka, president; Melvin M. Simmons, president-elect and Lloyd J. Duest, secretary, all of Sarasota. Re-elected treasurer was Dr. Millard B. White, also of Sarasota.

Seminole

The officers of the Seminole County Medical Society for 1954 are Drs. J. Clifford Boyce, president; John M. Morgan, vice president; and Terry Bird, secretary-treasurer, all of Sanford.

Suwannee

Dr. William P. Blackmon of Mayo is the new president of the Suwannee County Medical Society. Dr. Alex Kish of Live Oak is the vice president for the coming year, and Dr. Hiram B. Curry of Jasper is the secretary-treasurer.

Taylor

New officers of the Taylor County Medical Society are Drs. George H. Warren of Perry, president, and Walter J. Baker of Foley, secretary-treasurer.

Volusia

Dr. Cleland D. Cochrane of Daytona Beach was elected president of the Volusia County Medical Society for 1954. Dr. Arthur Schwartz is the new vice president, and Dr. Ruth T. Rogers is the corresponding secretary. Re-elected to office was Dr. Robert L. Miller, secretary-treasurer. All officers are from Daytona Beach.

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Walton-Okaloosa

Dr. Robert von P. Maxon of Fort Walton is the new president of the Walton-Okaloosa County Medical Society; Dr. Samuel E. Stephens of Laurel Hill is the vice president; and Dr. Arthur G. Williams Jr. of Valparaiso is the secretary-treasurer.

Washington-Holmes

President of the Washington-Holmes County Medical Society for 1954 is Dr. Ralph H. Segrest of Bonifay. Dr. Bayllye W. Dalton of Chipley is secretary-treasurer.

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Mrs. A. Fred Turner, Jr., Hospitality.....*Orlando*
Mrs. William D. Rogers, State Project....*Chattahoochee*

New Threshold

No one who attended the Fall Board Meeting of the Woman's Auxiliary to the Florida Medical Association or who received a copy of the minutes can doubt that we are on the threshold of new achievement.

When a group which has been absorbed by the all consuming task of becoming organized can turn its attention with confidence to a project which utilizes the energy and direction of this statewide organization, we can assume the round-up is over and the drive is on.

The project selected for the year 1953-54 and headed by Mrs. William D. Rogers is Mental Health. This announcement was greeted with enthusiasm for it has long been the wish of the Auxiliary to have sufficient cohesion of its membership to do something in this field.

Ideas once expressed are like seeds scattered over a field. The time of sowing may not always yield the properties which make the ground immediately fallow, but persistent nourishment of the soil by those who are faithful to the groundwork as well as constancy of each hand that yearly guides the plough through this Auxili-

ry field make possible the eventual flowering of n ideal.

The provision of basic equipment for a two-hair beauty shop at the State Mental Hospital n Chattahoochee through the voluntary contri-outions of all Auxiliary members is far more than asic in achievement. Vision, understanding and ompassion are revealed in this gesture, indicating n awareness of problems and a willingness to al-eviate some of the bleakness of institutional life or the mentally afflicated.

This, nevertheless, is but a beginning; and the rend, however propitious, to be augmented, must e accompanied by a concerted effort in each ounty Auxiliary to educate its members on the ubject of Mental Health. For only with a de-eloped insight into this increasing problem may ve become effective ambassadors of the helpless o organizational centers, as well as to individual ources who can and wish to be helpful.

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OBITUARIES

Banks H. Goodale

Dr. Banks H. Goodale of Jacksonville died on Oct. 8, 1953 in a local hospital after a lengthy illness. He was 66 years of age.

Born in Albemarle, N. C., in 1887, Dr. Goodale attended Wake Forest College and received his medical training at the Southern College of Medicine and Surgery in Atlanta, Ga., where he was graduated in 1912.

Dr. Goodale was licensed to practice medicine in Florida in October 1914. He located in Jacksonville, where he engaged in the general practice of medicine until his retirement in 1950. Locally, he was a life member of Ionic Lodge 101, F and AM and a member of the Springfield Presbyterian Church.

Dr. Goodale was an honorary member of the Duval County Medical Society. Since 1919 he had been a member of the Florida Medical Association, holding honorary status for the last three years. He was a fellow of the American Medical Association and a member of the Southern Medical Association.

Surviving are the widow, Mrs. Cassie B. Goodale of Jacksonville; two daughters, Mrs. George D. Arnette of Jacksonville and Mrs. Ernest Prevatt of Alaska; a brother, E. B. Goodale of Columbia, S. C.; a sister, Mrs. Oscar Young of Rockingham, N. C.; four grandchildren, and a nephew, Vernon L. Goodale.

Saul Joseph Pearlman

Dr. Saul Joseph Pearlman of Miami Beach died on Oct. 6, 1953 at the age of 57.

A native of New York City, Dr. Pearlman was graduated from Fordham University School of Medicine in 1919. Following an internship at Harlem Hospital in New York City, he specialized in urology, taking postgraduate training in general surgery and urology at the New York Post-Graduate Medical School from 1923 to 1927. Further study abroad in Budapest, Hungary in 1930 and 1931 brought him training with outstanding European urologists. He then engaged in the practice of his specialty in Brooklyn, N. Y., and Passaic, N. J., until he entered military service.

From 1943 to 1949 Dr. Pearlman served with the Armed Forces, holding the rank of lieutenant colonel. For two years he was Chief of Urology with the 37th General Hospital in the African and Mediterranean campaigns. Continuing in service after the termination of hostilities, he was assigned as Chief of Urology at several Army general hospitals, including Fitzsimons, Madigan and Brooke General hospitals in this country.

For four years prior to his death, Dr. Pearlman was actively engaged in the practice of urology in the Miami area. He was a member of the visiting staffs of Mt. Sinai and St. Francis hospitals in Miami Beach and Mercy and Victoria hospitals in Miami. A devoted student of his specialty, he was an able teacher, and his contributions to medical literature were numerous and varied.



Dr. Pearlman was a member of the Dade County Medical Association, and since 1951 had been a member of the Florida Medical Association. He also held membership in the American Medical Association, the Southern Medical Association, the American Urological Association, the New York Urological Society and the Florida Urological Society. He was a diplomate of the American Board of Urology and of the International College of Surgeons and a fellow of the Southeastern Surgical Congress and the American Geriatric Society.

Surviving are the widow, two brothers and a sister.

Rufus Thames

Dr. Rufus Thames of Milton died in the Santa Rosa Hospital in that city on Oct. 26, 1953. He was 79 years of age.

On Dec. 14, 1874, Dr. Thames was born in Burnt Corn, a small farming community in Alabama. He received his medical training in Atlanta, where he was graduated from the Atlanta College of Physicians and Surgeons in 1906.

Soon after graduation, Dr. Thames entered the general practice of medicine in Jay and through 47 years continued to devote his professional career to Santa Rosa County. The early years of his practice were spent in the horse-and-buggy era, and not infrequently he made calls on horseback in the rugged sections, but later he owned the third automobile in the county. By avocation, he was a farmer, owning several farms where he raised cattle. Affectionately known as "Doctor Rufe" throughout the community, he had delivered more than 3,000 babies since 1917, when vital statistics on births were first recorded. Among his greatest interests was the hospital where he died. He worked actively for several years in promoting this recently completed project.

Dr. Thames was the oldest member of the Escambia County Medical Society and was known for his record attendance at its meetings, held in Pensacola. A member of the Florida Medical Association for 40 years, he had held honorary status for the last five years. In 1948, he was chosen by the Association as Florida's outstanding general practitioner of the year. He was also a member of the American Medical Association.

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Then yesterday, I got a postcard at the office—from the Missus herself! It read: "Thanks, Joe, for mailing my letters." Well! Looks like she figured I *still* needed some checking-up and slipped that postcard in the last batch of letters.

From where I sit, an occasional check-up is a good thing. Like a check-up on our tolerance, for instance. I promise not to tell you what beverage to drink or how to practice your profession. Now I like a glass of beer with supper, you may prefer tea—but if I try to switch you to my choice, please "address" me with a reminder of your rights.

Joe Marsh

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In 1912, Dr. Thames and Miss Ora Byrom of Calhoun, Ga., were united in marriage. Mrs. Thames died in 1933. His survivors include three sisters, Mrs. John Waters and Mrs. Jim Wells of Burnt Corn, and Mrs. J. B. Norred of Pensacola; one brother, Dan Thames of Burnt Corn; a niece, Mrs. Christine Green, and her son, Paul, who have lived at his home for a number of years, and several other nieces and nephews.

Oliver Pickering Broadbent

Dr. Oliver Pickering Broadbent of Jacksonville died suddenly on Nov. 22, 1953 while en route to a local hospital following a heart attack. He was 60 years of age.

Born in Elwood, Ind., Dr. Broadbent received his education in his native state. He attended Purdue University for two years and in 1924 was awarded the degree of Doctor of Medicine by the Indiana University School of Medicine.

In 1925 Dr. Broadbent located in Jacksonville and since that time had engaged in the general practice of medicine there. He was a veteran of World War I.

Dr. Broadbent was for 28 years a member of the Duval County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association. He was a member of the Acacia Fraternity.

Surviving are the widow, Mrs. Nadine H. Broadbent; one son, Robert Hoyle Broadbent, a student at the University of Florida; two sisters, Miss Ada Broadbent of Cincinnati, Ohio, and Mrs. Herman Platz of Milwaukee, Wis.; and a brother, Richard Broadbent of Kentucky.

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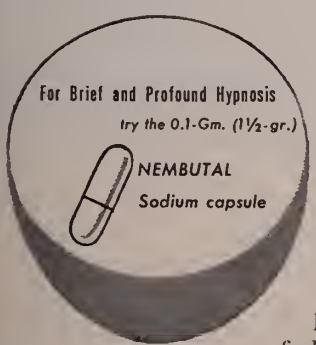
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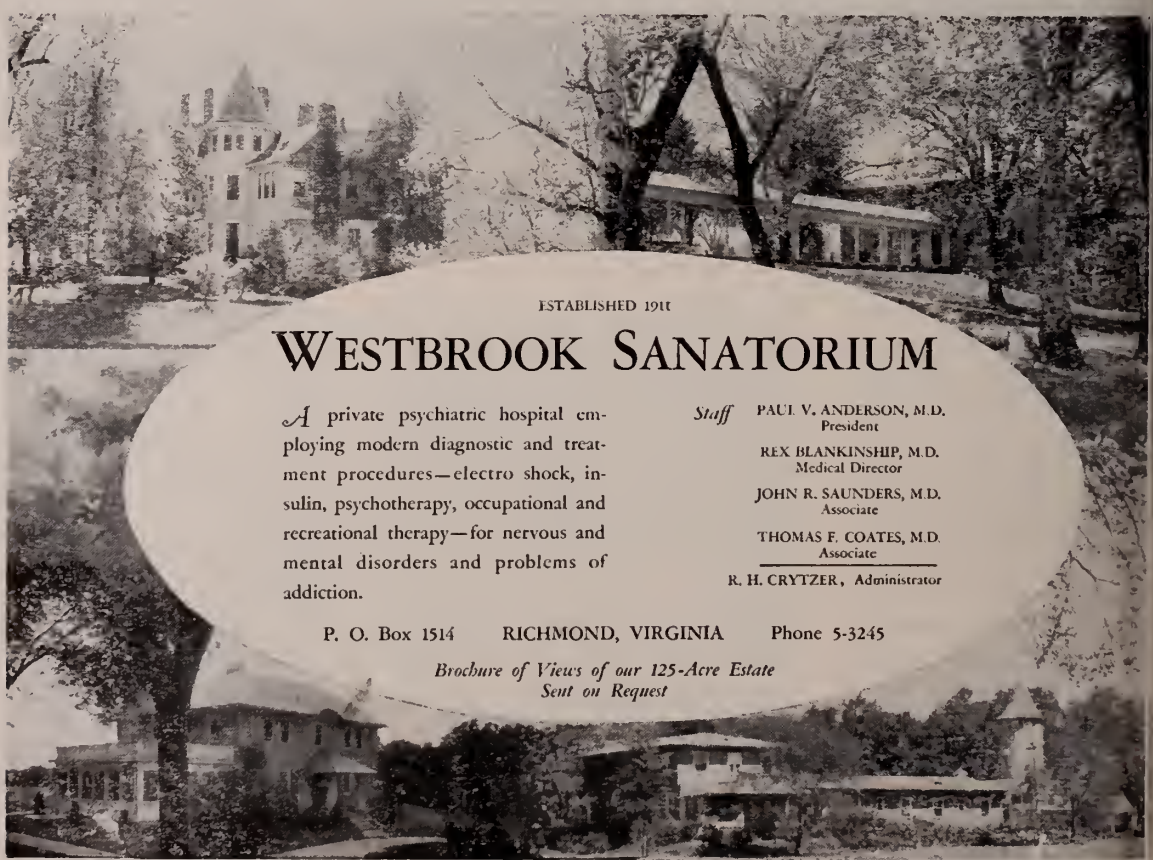
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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
Medical Districts	John D. Milton, Miami	Council Chairman	
rthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
rtheast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
uthwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
utheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
Specialty Societies			
y of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	Hollywood, Apr. 25, '54
Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
siologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
nd Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
ial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
gy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
dic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	" "
gists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	" "
c Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
gic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	" "
gical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	" "
cal Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	" "
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
l Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
r Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	Hollywood, Apr. 25, '54
al Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, 1954
l Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, Apr. 25-28 '54
Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
tal Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
cal Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	
Anesthetists, Fla. Assn.	Miss G E. Keyes, Daytona Beach	Mrs. Lillie Crouch, Daytona Beach	Atlanta, April '54
s Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
naceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May 10-12 '54
Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
au Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	St. Petersburg, Apr. 9-10, '54
culosis & Health Assn.	Leffie M. Carlton Jr., Tampa	Mrs. L. C. Conant, Fort Myers	" "
an's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers Jr., Cocoa	Hollywood, Apr. 25-27, '54
n Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 30-Dec. 3, '54
n Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
n Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
Medical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
spital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
stern Allergy Assn.	W. Lindsay Miller, Gadsden, Ala.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, Mar. 25-27 '54
stern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
stern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
ast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	47
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James M. Nixon, Panama City	1st Tues.	23
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	26
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	97
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	622
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	253
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	94
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	6
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	177
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	6
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	25
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	31
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	51
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
St. Lucie-Okeechobee-Martin	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	21
Sarasota	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	26
Seminole				
Suwannee	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	13
Taylor	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
***Dixie, Lafayette**	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	166
Volusia				
***Flagler**	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	128
Walton-Okaloosa	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Washington-Holmes	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	183
Manatee	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	89
Marion	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	9
***Levy**	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	16
Monroe	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	16
Nassau	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	48
Orange	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	19
***Osceola**	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	8
Palm Beach	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
Pasco-Hernando-Citrus				
Pinellas	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	75
Polk				
Putnam	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	15
St. Johns	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		4
			Total	2,385

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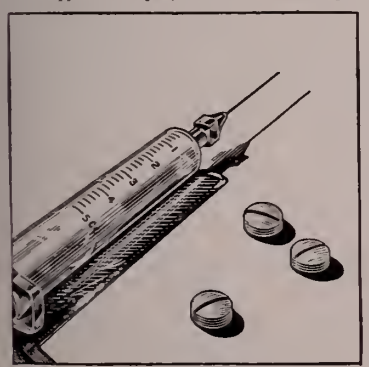
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Sore Tongue
Abraham R. Hollender

Problems of Tumor Clinic Director
Francis T. Holland

Cat Scratch Disease
James J. DeVito

Malpractice and Insurance
Samuel M. Day

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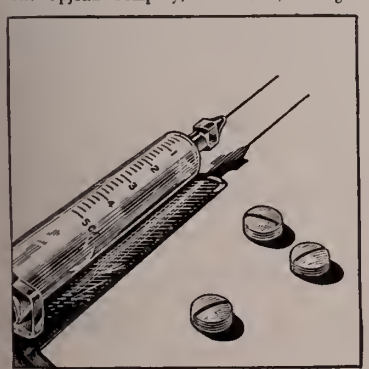
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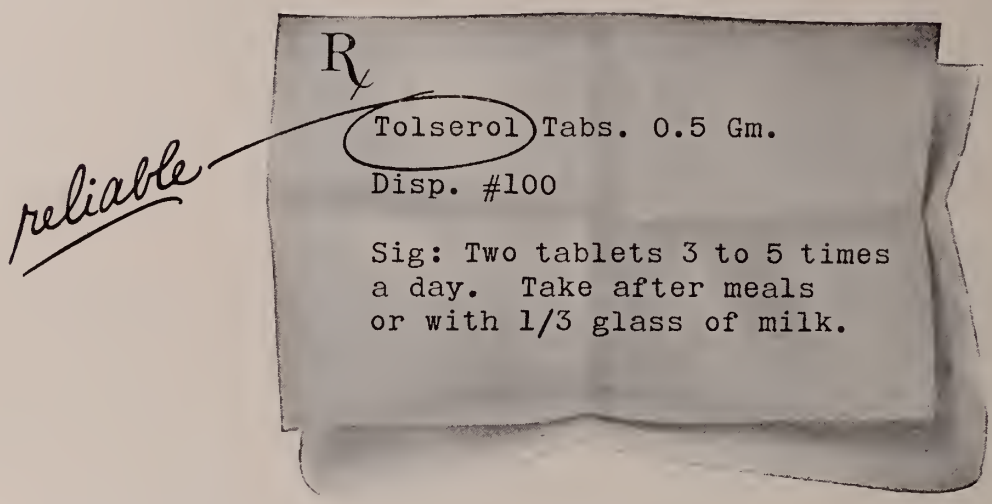
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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet *2*:1002 (Dec. 1) 1951.
2. Wilkins, R.W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.

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1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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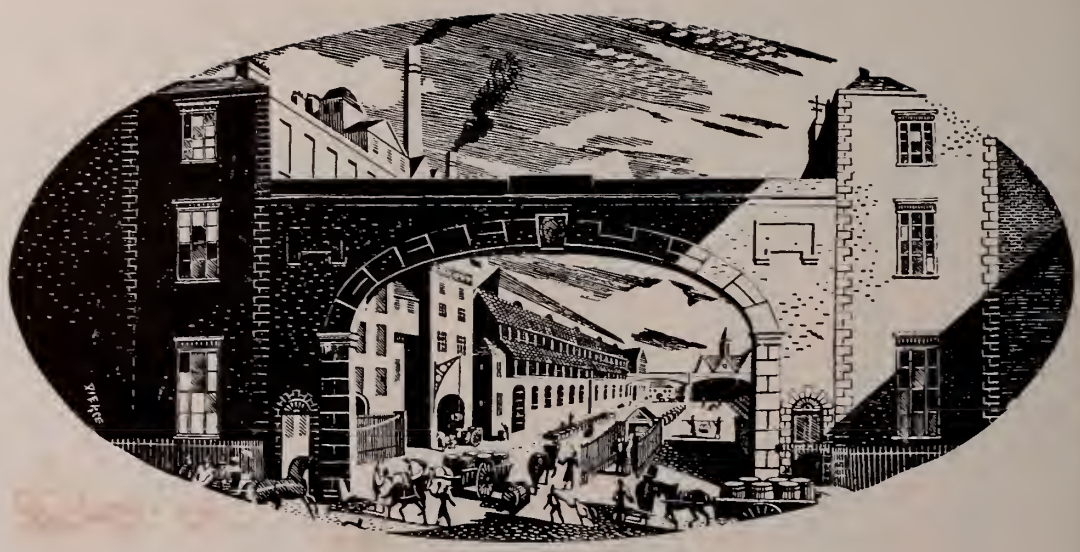


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1. Sayer, R. J., et al.: Am. J. M. Sc. *221*:256 (Mar.) 1951.
2. Welch, H.: Ann. New York Acad. Sc. *53*:253 (Sept.) 1950.
3. Werner, C. A., et al.: Proc. Soc. Exper. Biol. & Med. *74*:261 (June) 1950.
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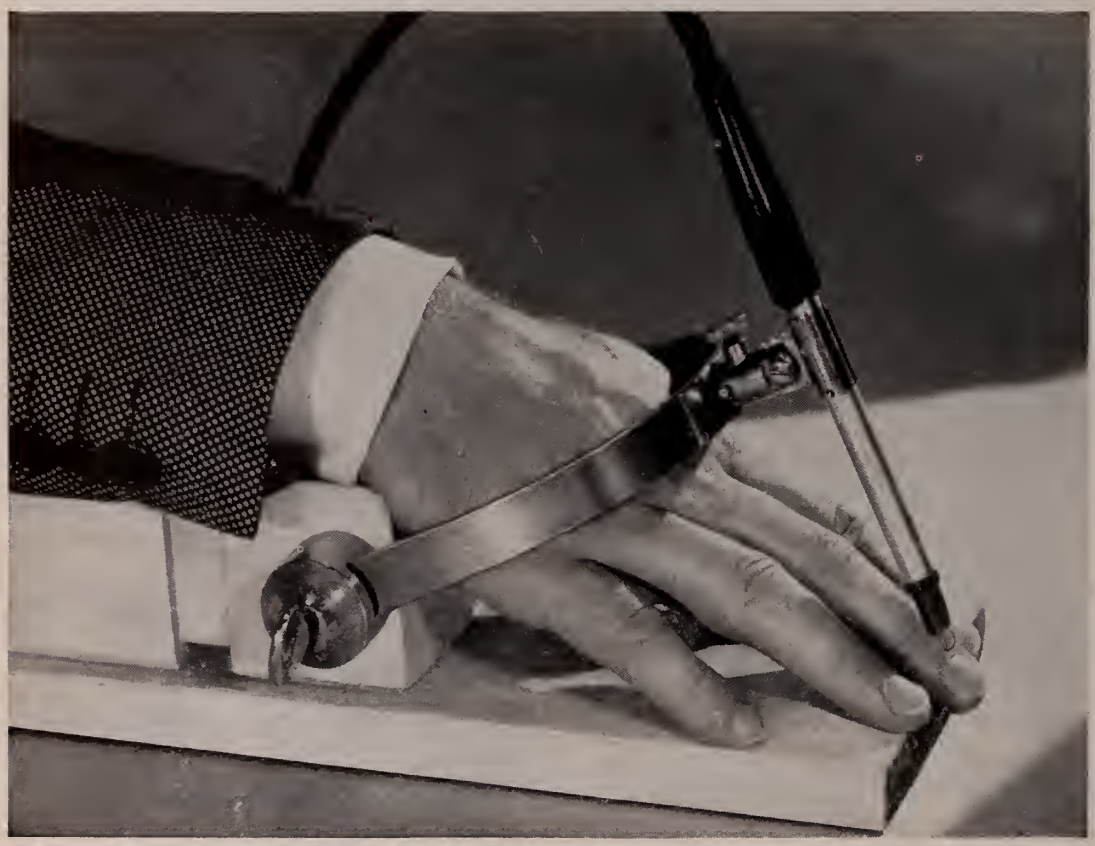
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1. English, A. R.; P'an, S. Y.; McBride, T. J.; Gardocki, J. F.; Van Halsema, G., and Wright, W. A.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.
2. Finland, M.: Brit. M. J. 2:4846 (Nov. 21) 1953.

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1. McLester, J. S., and Darby, W. J.: Nutrition and Diet in Health and Disease, ed. 6, Philadelphia, W. B. Saunders Company, 1952, pp. 287-299.

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Atresia of the Esophagus With Tracheoesophageal Fistula

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AND
NATHAN WEIL, M.D.
JACKSONVILLE

Esophageal atresia with tracheoesophageal fistula is inevitably fatal if untreated. Recent wide experience with cases of this type has made it possible to save over half the infants so afflicted. The purpose of this communication is to summarize the anatomic and clinical features of the condition and to describe its surgical management. Emphasis will be placed upon the necessity for early diagnosis.

We are reporting 4 cases with 2 survivals.

Pathology

The embryologic explanation of atresia of the esophagus and tracheoesophageal fistula has been well presented in the literature.[1,3] Suffice it to say that both the trachea and esophagus develop from the primitive foregut, which consists of one tube in early fetal life. Aberrations in the process of separation of the one tube into two account for the anomaly which we are considering.

The incidence of this anomaly has been variously estimated at from 1 in 800 births[4] to 1 in 2,500 births.[3] Though unusual, it occurs often enough to arrest the attention of those who are responsible in any way for the care of the newborn.

The variations which this condition may assume have been classified by Ladd[5] into five types (fig. 1). It has been established that 85 to 90 per cent of these anomalies fall into types III and IV,[2,6,7] the great majority being type III. It has been noted further that in up to 85 per cent of this group the esophageal segments lie close enough together to permit their anastomosis.[7] The upper esophageal segment ends in a blind pouch at about the level of the second thoracic vertebra. The lower segment communicates with the trachea just above the bifurcation or at the carina. In a few cases the lower esophageal segment is atretic, extending only a short distance above the diaphragm. These anatomic variations have considerable clinical significance.

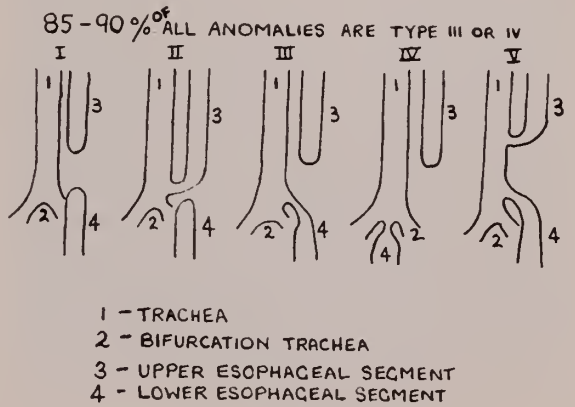


Fig. 1.—Ladd classified the variations of atresia of the esophagus and tracheoesophageal fistula into five types which are illustrated above.

Diagnosis

A high index of suspicion on the part of the physician is essential if the diagnosis is to be made when operation can be performed with the greatest margin of safety. The optimum time for

Read before the Florida Medical Association, Seventy-Ninth Annual Meeting, Hollywood, April 27, 1953.

surgery is during the first 48 hours of life. In most of the reported cases with successful outcome, surgery was performed before the sixth day. In 1 case of our series, however, the infant was not subjected to surgery until the eighth day of life, but made a good recovery.

Weiss and Miangolarra[8] pointed out that esophageal atresia should be suspected in the first 15 minutes of life if the infant brings up excessive amounts of frothy saliva in spite of efforts to dry the mouth by repeated aspiration. They advise passage of a catheter immediately to determine whether there is an esophageal obstruction. They operated successfully on an infant at the age of six hours, the youngest such patient surgically treated whose case has been reported to date.

Atresia of Esophagus with Tracheoesophageal Fistula

Signs and Symptoms

(1) Excessive drooling of frothy mucus
(2) Choking, coughing and difficult breathing
(3) Immediate regurgitation of feedings associated with choking, coughing and cyanosis.

Figure 2

All infants having excessive oral secretions do not have esophageal atresia, but all patients with atresia do have excessive secretions. It would seem wise to pass a catheter in all such infants so that the occasional lesion will not be overlooked.

In addition to the unusual secretions mentioned, coughing, choking, difficult breathing and bouts of cyanosis are typical in cases of this type (fig. 2). These signs and symptoms are due to two factors. The saliva is regurgitated out of the blind esophagus, part of it entering the trachea. In the same manner, if feedings are offered, they may be largely aspirated into the trachea and thence into the lungs. The respiratory function is further impaired by the regurgitation of gastric juice through the tracheoesophageal fistula into the trachea. Feedings will always precipitate seizures of the symptoms and should never be offered these patients. If diagnosis and treatment are delayed, a patchy aspiration pneumonia soon develops along with a varying degree of atelectasis. The prognosis worsens as these conditions progress.

Atresia of Esophagus with Tracheoesophageal Fistula

Diagnostic Steps

(1) Passage of esophageal catheter to demonstrate obstruction
(2) Injection of iodized oil to show atresia or fistula of upper segment
(3) Roentgenogram of abdomen — air in stomach diagnostic of tracheoesophageal fistula

Figure 3

To confirm a suspected diagnosis a definite routine is followed (fig. 3). An 8 to 10 French soft rubber catheter is introduced through the oropharynx into the esophagus. If there is atresia, the catheter will meet obstruction at about 10 to 12 cm. from the lip margin. About 2 cc. of iodized oil is instilled through the catheter under the fluoroscope. Anteroposterior and lateral roentgenograms are taken (figs. 4 and 5). If atresia is present, the oil will puddle in the esophagus showing the lesion clearly. If tracheoesophageal fistula is present, roentgenograms of the abdomen will show air in the stomach and bowel, a sign which is diagnostic of this lesion. Only rarely will a fistula be present if there is no air in the stomach (fig. 6). In addition, the chest is evaluated carefully for signs of pneumonia (fig. 7).

One should be mindful that in these cases the incidence of other anomalies, for example, imperforate anus, is much higher than average.[2]



Fig. 4. — Case 3. This anteroposterior radiogram was taken after instillation of iodized oil into the upper esophageal segment, the atresia of this segment being clearly shown. Air is plainly visible in the upper part of the gastrointestinal tract and, in the presence of atresia of the upper portion of the esophagus, is pathognomonic of tracheoesophageal fistula.

Treatment

Preoperative Preparation

Preparation of these little patients is important and should be accomplished as rapidly as possible. Close liaison between the pediatrician and the surgeon is essential. If the child is less than two days old, he usually has not been fed and has no pneumonia. Preparation consists simply of administration of penicillin and streptomycin and a small clysis. The pharynx is cleared of secretions by repeated suction. A small dose of atropine may be given. A transfusion is readied for use during surgery.



Fig. 5.—Case 3. This radiogram is a lateral view of the same patient as in figure 4. The atretic upper portion of the esophagus again stands out, and air is obvious in the bowel and stomach.

If the child is older, has pneumonia from attempted feedings, and is dehydrated, additional measures must be taken. The chest should be carefully evaluated. Efforts are redoubled to clear the trachea and pharynx of secretions. The patient is transfused. Vitamins C and B are given parenterally. Such preparations should require less than 12 hours.

Operation

It is fortunate that about 90 per cent of the lesions are type III or IV, as these types lend themselves best to surgical correction. The objective is to disconnect the tracheoesophageal fistula and perform a direct anastomosis between the upper and lower esophageal segments. This operation, first successfully used by Haight in 1941,[9] has been employed in well over 500 cases to date with a steadily declining mortality. The names of Haight,[9] Ladd,[5] Lanman,[1] Leven,[10] Gross,[11] and Potts[6] are associated with the development of this procedure. Ladd and Swenson[2] reported a mortality of 60 per cent in 82 cases in 1947, but in the last 14 of these in which a primary anastomosis was performed, there was only 1 death.

The surgical technic, now well standardized, has been described in detail in several excellent papers.[2,5,6,12] Only a brief outline, supported by illustrations, will be presented here.



Fig. 6.—Case 4. This anteroposterior radiogram shows the complete absence of air from the gastrointestinal tract in a patient known to have atresia of the upper segment of the esophagus. A diagnosis of atresia of the lower esophageal segment, made by radiogram, was substantiated at operation (type I anomaly).

General anesthesia is necessary. A cannula is fixed in a vein, and the patient is placed in a face-down position. The incision is made on the posterior wall of the right side of the chest curving downward and laterally around the medial and

inferior scapular borders (fig. 8). One or more ribs (usually the third and fourth) are resected, and an extrapleural exposure of the mediastinum is developed (fig. 9). The upper and lower esophageal segments are identified and mobilized. The fistula is disconnected and the trachea sutured (fig. 10). The esophageal segments are anastomosed with 000000 silk, two layers of interrupted sutures being used (figs. 11 and 12). We prefer to perform this anastomosis over a small rubber catheter placed in the esophagus as this assures a lumen. The catheter or a polyethylene tube is left in place and used for feedings postoperatively. The wound is closed in layers and drained extrapleurally.

A blood transfusion is given during surgery.



Fig. 7.—Case 4. This radiogram shows iodized oil in the lung field as well as in the blind upper segment of the esophagus. It illustrates the danger from instilling too much oil during the diagnostic study.

Postoperative Care

The patient is kept in oxygen in an incubator for about a week. As before operation, the surgeon and pediatrician work together through the postoperative period. Penicillin and streptomycin as well as supplementary vitamins are given parenterally. Fluid balance is maintained with appropriate solutions, blood, and plasma given by constant slow intravenous drip. Small amounts of glucose water are fed through the polyethylene tube, which is removed on about the fourth postoperative day. If one feels insecure about the anastomosis, the tube can be left in longer. After its removal, sterile water, several cubic centimeters at a time, is fed by mouth. Should no leakage from the wound occur, weak milk mixture is started on the sixth day, and the feedings are increased so that in another week the child is receiving a normal diet.

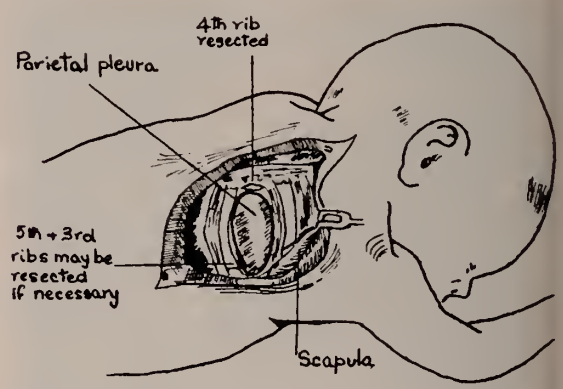


Fig. 8.—This illustration shows the position of the infant on the table and the incision.
Courtesy, Potts, W. J.: Congenital Atresia of Esophagus with Tracheoesophageal Fistula, J. Thoracic Surg. 20:671-680 (Nov.) 1950.

Should leakage from the wound occur after feedings, a gastrostomy is performed, and the infant is fed through this opening until the anastomosis has healed.[6] Gross and Scott[11] advised routine gastrostomy for postoperative feedings. Stricture at the anastomosis will occur in some cases and should be suspected if difficulty in swallowing develops. Esophageal dilatation is indicated in such cases and should afford relief.

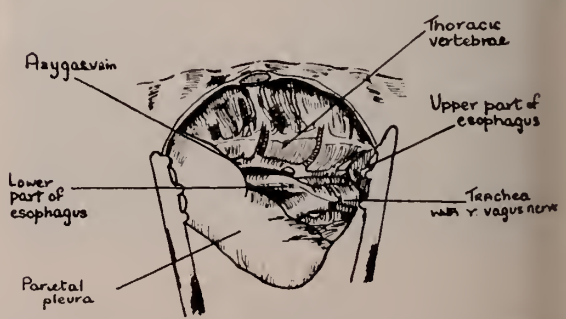


Fig. 9.—This illustration shows the posterior mediastinal structures exposed through the posterior extrapleural approach.

Comment

Should the surgeon find that for any reason the esophageal segments cannot be anastomosed, he must immediately revise his plan. The tracheoesophageal fistula, if present, is disconnected, for no patient can survive with a fistula.[2] The wound is closed, and two days later an esophagostomy is performed, bringing the upper esophageal segment out in the left side of the neck just above the clavicle.[2] Two or three days after this

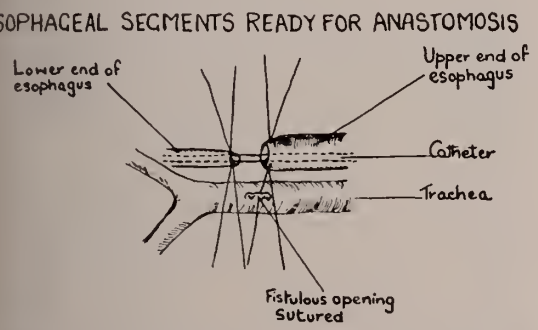


Fig. 10.—The disproportion between the diameter of the upper esophageal segment and lower segment is well known. This is a constant finding in these cases.

procedure a gastrostomy is performed for feedings.[2] When the patient is a year or more old, continuity can be restored by constructing a skin tube from the chest wall, or by bringing either the stomach or bowel up for direct anastomosis at the esophagostomy.[2] Experience has shown that this plan offers the safest way out of a difficult situation.

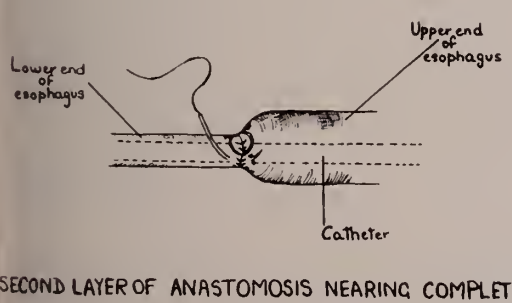


Figure 11

Discussion of Cases

We have had personal experience with 4 cases of esophageal atresia, in 3 of which there was an associated tracheoesophageal fistula. In the fourth case the lower esophageal segment was represented by an atretic cord which did not extend above the diaphragm. The child in this case was one month premature and died two hours after operation. Had he lived, stage operations would have been necessary to attain esophagogastric continuity. The other fatal case was one in which the diagnosis and operation were late, the child having well developed bronchopneumonia. In this case an anastomosis was not possible because the upper esophageal segment was abnormally high and could not be approximated to the lower segment. This infant died under operation. Had he lived, a stage procedure might have been necessary.*

The remaining 2 patients survived operation, and both are developing normally. One is 7 years of age and the other just under 1 year. Each had a classical type III anomaly. Anastomosis was possible in both cases (fig. 13). The 4 cases of this series are being reported briefly to illustrate the various aspects of this problem. It is hoped that our experiences may prove useful to others.

Report of Cases

Case 1.—S. B., a white female infant weighing 6 pounds and 1 ounce was delivered spontaneously at term on Oct. 8, 1947. The cry was spontaneous and the color good. Six hours after birth the infant had several attacks of cyanosis which lasted two to five minutes and began to cough up a great deal of thick, tenacious mucus. The infant was placed in an incubator and oxygen administered at 6 liters per minute. No feedings were given, and penicillin therapy was started. There were a few fine rales at the apices of

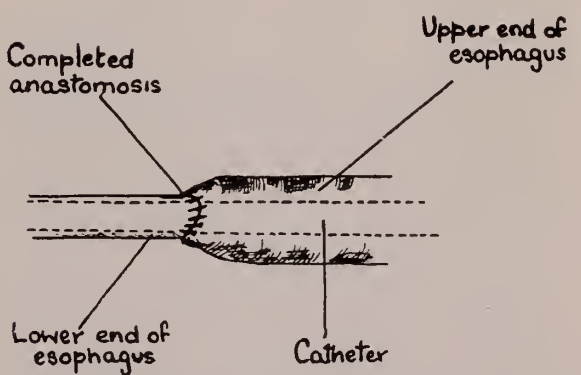


Fig. 12.—If possible, it is desirable to telescope the lower segment into the upper with the second layer of the anastomotic sutures.

*Shortly after this paper was presented, we learned that Gross[13] now is of the opinion that a transthoracic approach is desirable in these cases so that when primary esophageal anastomosis is not possible, the stomach may be mobilized, brought up into the chest, and a primary esophagogastric anastomosis performed. In this way, stage operations are obviated.

both lungs. During the next five days the child coughed up and vomited mucus, but cyanotic attacks were infrequent. Fluids were administered by clysis and two blood transfusions given. On the sixth day of life the diagnosis of tracheoesophageal fistula was established by roentgen examination including fluoroscopy. The lungs were clear, and there was normal gas pattern in the upper portion of the gastrointestinal tract.



Fig. 13.—Case 3. This radiogram shows barium passing through the anastomosed esophagus three months postoperatively. Only a slight indentation marks the sight of the anastomosis.

On the eighth day of life the infant was operated upon, the tracheoesophageal fistula closed and the esophagus properly anastomosed over a rubber catheter. This catheter, passed orally through the esophagus and into the stomach, was left in place for later feedings. Postoperative shock was minimal. Fluids were administered through a continuous drip, and one transfusion was given immediately after surgery. Antibiotics, both streptomycin and penicillin, were administered for six days.

Eighteen hours after surgery feedings were initiated through the rubber catheter and tolerated well. Within three days normal amounts of milk mixture were given without incident, the weight had become stabilized, and the infant was beginning to gain. On the tenth postoperative day the catheter was removed, an anterior gastrostomy was performed, and feedings were carried on through the gastrostomy tube for another week. At this time the infant was allowed to take feedings from the nursing bottle. As there was no distress or regurgitation, the gastrostomy was allowed to close.

During the second week postoperatively bronchitis developed along with atelectasis of the upper lobe of the right lung, which responded well to routine therapy. Further roentgen studies revealed a moderate constriction at the site of the anastomosis. The patient was hospitalized on Jan. 10, 1948, because of recurrent respiratory infections, but gained well and manifested normal development in this interval. Because any attempt to offer thick feedings such as cereal, fruit and vegetables caused dysphagia, the infant was sent to Richmond, Va., on March 22 to Dr. Porter Vinson, who was able to pass initially a 23F sound followed by a 27F sound. There was little obstruction present, and the infant ate normally following this procedure. Since that time the patient has been followed continuously, has developed normally, and has been free of obstructive symptoms.

It is well to state that while diagnosis was relatively late in this case, the fact that no feedings had been attempted was a most favorable factor in the ultimate recovery of this patient.

Case 2.—B. G., a Negro male infant weighing 5 pounds and 11¼ ounces was delivered spontaneously at term on Dec. 12, 1948. The first four days of life were marked by excessive drooling of frothy mucus requiring frequent suctioning. The infant was kept in oxygen, penicillin was given, and feedings were withheld because of poor breathing and oral secretions. The diagnosis was suspected and confirmed by passage of an oral catheter and roentgen studies on the fifth day of life. The anomaly was of type III, there being an atresia of the upper esophageal segment and a fistulous connection between the trachea and lower esophageal segment. Gas was noted in the stomach and bowel on the initial roentgenogram, establishing the diagnosis of tracheoesophageal fistula. At operation on December 17, the sixth day of life, anastomosis could not be performed as the esophageal segments, when fully mobilized, failed to meet by 4 cm. The child did poorly during surgery and expired on the operating table. Death was due to respiratory failure. Autopsy showed great congestion of both lungs.

This infant could probably have been saved had diagnosis and treatment been instituted earlier. Instead of a direct anastomosis, a stage operation might have been necessary here.

Case 3.—W. G. M., a white male infant weighing 7 pounds and 12 ounces was delivered spontaneously at term on May 17, 1952. He was the second child born to a 27 year old mother who had experienced no infections or difficulties during pregnancy. There was no significant family history.

During the first 24 hours of life excessive mucus in the mouth and nose, requiring aspiration, was noted. At 31 hours of age medium and fine moist rales were observed throughout both sides of the chest. Atresia of the esophagus being suspected, an attempt was made to pass a catheter into the stomach. Obstruction was encountered high within the esophagus. No food or water had been fed the infant. Roentgenologic examination of the esophagus with the use of iodized oil showed an obstruction at the level of the third thoracic vertebra. Barium was not used because of the danger of aspiration into the lung, where it is highly irritating. The lungs were clear. A moderate amount of gas was observed in the stomach and intestines, indicating a communication between the trachea and esophagus.

Immediate surgery was planned. The patient was given a clysis of 50 cc. of 2½ per cent glucose in distilled water, 50 cc. of blood intravenously, 200,000 units of penicillin procaine, and 3 mg. of vitamin K.

Operation was performed when the patient was 32 hours of age. The usual extrapleural approach was made through the right side of the chest posteriorly. A type III lesion was found, there being a blind upper esophageal segment and a fistula between the trachea and the lower esophageal segment. The fistula was disconnected, and an end to end anastomosis was performed between the esophageal segments. The anastomosis was performed over a catheter, which was replaced by a polyethylene tube introduced before the wound was closed and guided through the anastomosis under direct vision. The wound was closed in layers and drained through a stab wound below the incision.

The patient arrived from the operating room in good condition. He was placed in an incubator with regulated oxygen. The drainage tube from the operative site was run under water. An intravenous drip was started through a scalp vein. He was sustained on glucose solutions, saline solutions, daily plasma and one blood transfusion during the first five postoperative days. Terramycin, 45 mg. each 24 hours, was given intravenously for five days and penicillin procaine 200,000 units intramuscularly for eight days. He was sent from the operating room with a polyethylene tube leading from the stomach, through the repaired esophagus, and out the nose. This was pulled out by the baby on the first postoperative day.

Administration of 2 cc. of sterile water every hour by mouth was started on the third postoperative day and a weak evaporated milk mixture on the fifth postoperative day. On the sixth postoperative day he was taking sufficient foods so that parenteral fluids were no longer required. At no time did he vomit. Roentgenologic examination on the second postoperative day revealed a small area of increased density at the base of the right lung suggestive of pneumonia. In both the supine and erect positions no fluid in the chest cavity was seen. The next day, however, roentgen examination showed a pneumothorax on the right side with almost complete collapse of the right lung.

Meanwhile, the infant was showing no cyanosis, dyspnea, coughing, or vomiting of glucose water. At no time did his temperature rise above 100.4 F. rectally. The drainage tube and the sutures were removed from the chest on the sixth postoperative day, and the wound healed without infection. He left the hospital in excellent condition weighing 7 pounds and 13 ounces at the age of 17 days.

The child developed well after discharge. Cereal was started at eight weeks of age and strained fruits at 10 weeks of age. There was no difficulty in swallowing. A pronounced stridor was noted from the time of discharge and has continued. Direct laryngoscopic examination revealed no palsy of the vocal cords.

Roentgenologic examination of the esophagus at five weeks of age with a barium feeding showed only slight narrowing at the operative site. At nine and one-half months he suddenly started choking when eating food. Esophagoscopic examination was necessary, and a rounded piece of wax crayon was removed from the esophagus at the level of the anastomosis. The esophagus was dilated at this time. The anastomosis, visualized through the esophagoscope, was well healed and in good condition.

Case 4.—B. B., a white male infant weighing 3 pounds and 11 ounces was delivered spontaneously on Nov. 6, 1952. This baby was delivered at eight months, being one month premature. Because of continued abnormal drooling of white foamy mucus, atresia of the esophagus was suspected two days after birth. Passage of a catheter revealed obstruction in the upper portion of the esophagus, substantiated by roentgenograms taken after instillation of iodized oil. It is significant that these roentgenograms showed that air was completely absent from the gastrointestinal tract (fig. 6), thus forecasting the absence of a tracheoesophageal fistula and an atresia of the lower esophageal segment (type I anomaly).

At operation on the fourth day of life, the usual posterior extrapleural approach on the right side was made. The upper blind esophageal segment was easily located by having the anesthetist insert a catheter orally and move it about in the esophagus. An extensive search failed to reveal a lower esophageal segment. The wound was closed, and a cervical esophagostomy was performed on the left side. The child expired two hours postoperatively.

Autopsy revealed a complete absence of the lower esophageal segment above the level of the diaphragm. There was great pulmonary congestion.

Experience has shown that the mortality is close to 100 per cent in premature infants of this sort.3 The prognosis would have been extremely poor even had a type III anomaly been found in which anastomosis was possible.

Summary

The anatomic and clinical features of esophageal atresia with associated tracheoesophageal fistula are presented, and the necessity for early diagnosis is stressed. The surgical management of this anomaly is discussed.

Four cases of esophageal atresia are reported, in 3 of which tracheoesophageal fistula was also present. There were 2 fatalities, and in the remaining 2 cases the patients made a good recovery and continue to develop normally, one after seven years and the other after one year.

While this abnormality occurs with relative infrequence, it nevertheless is encountered often enough to command the interest of obstetrician, pediatrician and surgeon alike. Noteworthy progress in its early recognition and treatment is reflected in steadily decreasing mortality.

Addendum

Since the presentation of this paper, we have had 2 additional cases. In 1 case, a type III anomaly was found, and an anastomosis was performed. The child died suddenly 18 hours postoperatively, the cause of death being undetermined. In the other case there was atresia of the upper esophageal segment, but no lower segment could be found. Gastrostomy and cervical esophagostomy were performed. The child is five months old and developing normally. An attempt will be made to establish continuity of the gastrointestinal tract when the child is from 1 to 2 years of age.

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2720 Park Street (Dr. Williams).

Discussion

DR. DEWITT C. DAUGHTRY, Miami: This has heen a most interesting presentation. We have not had stricture in our cases and we helieve that the meticulous technic of anastomosis helps in preventing strictures. If, however, the segments are a little difficult to get together, one does have to take more or less massive sutures and run a greater risk of having a stricture develop.

The diagnosis in one of our cases was most confused because the patient "vomited" hile and that delayed the diagnosis for a couple of days. It was only later, hy piecing the story together, that we could explain why the patient "vomited" hile and had atresia of the upper segment with connection of the lower segment to the trachea. He actually vomited the hile into the trachea and then coughed it up. If this possihility is kept in mind, it should not cloud or confuse the diagnosis.

Diagnosis of this condition is one of the easiest in medicine if one even suspects or thinks of the condition. Increased saliva ahout the mouth and, of course, any choking or cyanosis with the first feeding or fluids taken are the significant observations. In our most recent case the patient was six days of age when diagnosis was made and only after several attempted feedings.

We are rather optimistic ahout our recent results as we have had 3 survivals out of our last 4 cases. I am convinced that the use of a small polyethlene tuhe left in the reconstructed esophagus for feeding purposes helps greatly in recovery hecause nutrition can be properly maintained from almost the time of surgery. Gastrostomy seems a needless procedure.

It should he rememhered that it is easy to overhydrate these patients hy administration of parenteral fluid. It is our policy to keep them slightly dehydrated for the first few postoperative days.

DR. BRUCE M. HOGG, Miami: I have greatly enjoyed this paper and wholeheartedly agree with most of the statements made. I certainly believe that the ohstetricians and pediatricians should carry a high load of suspicion on every child who is horn with difficulty in respiration or excessive mucus, and with Dr. Daughtry I helieve all such children should have a catheter passed and at least have this anomaly ruled out. The more this is done, the more of these cases we will see and see early, although delay does not necessarily make the prohlem hopeless.

I recently analyzed 40 personal cases and 80 other pathologic and clinical cases and found that the average age of admission over the years was ahout six days, with a gradual improvement over the last ten years to 2 to 3 days with more awareness of the lesion being broadcast. In our series, 23 of the patients were horn in the adjoining maternity hospital. That represented ahout 75,000 hirths, which gives an incidence in that hospital of 1 in 3,200. I would have thought that was a slightly weighted figure, but Dr. Haight, to whom I talked recently, said that in his series there was only a small difference in the ratio, and he has a fairly well controlled area from which he draws.

In regard to technics, I think everyone works out his own. Personally, I have always used a two layer technic perhaps originally descrihed hy Dr. Haight or Dr. Swenson. I have forgotten who it was. One can skin out the mucosa from the upper segment pretty easily and make an anastomois with it and the lower segment, which is usually rather friahle and tender, then pull a cuff of muscle, which is usually hig in the upper segment, down over that as a huffer. The children whom we have seen have all had some degree of pneumonia, usually in the upper lobe of the right lung. The presence of air in the stomach and intestine is a good lead that there is a fistula, although as Dr. Williams said, occasionally there will be no air and there will still he a fistula. We have had that experience two or three times.

The children stand this procedure remarkahly well. I have recently contacted the surgeons in the country who have done most of the operations, and the percentages of survival range from 50 to 65. That is certainly a great improvement over what it used to he.

In regard to some of the little points, we have used gastrostomy practically routinely on the second day if the child is doing well. We tried leaving tuhes in and concluded that they perhaps did harm. Now I think the small polyethylene catheters used for premature infant feeding may he an answer that will he a satisfactory one. Certainly it is not too easy to keep a child in fluid halance hy purely intravenous feedings. Associated anomalies are another interesting feature. In our series they ran around 50 to 60 per cent and mayhe 15 per cent of them one could call serious. The only one, with all modern advances availahle, that I could have called incompatible with life was an agenesis of the kidneys. In the other cases there were varying anomalies. We had one patient with an imperforate anus, a rectourethral fistula and a tracheoesophageal fistula who is at present living and well at 5 years of age with good esophageal and rectal function.

The survival rates, as I said, were 50 to 65 per cent. There was a 52 per cent survival rate in our cases, hut that counts the period of learning, in which I think everyone has misfortunes. I am personally convinced that 90 odd per cent of these children probably have some possibility of a direct anastomosis. I helieve, too, that unless that can he done, esophagogastrostomy at the time, on the right, is perhaps the hest solution. The cases I have seen with reconstructed esophagus skin tuhes and others have not heen too satisfactory, and it has meant tremendous hospitalization time.

DR. WILLIAMS, concluding: I want to thank all the discussers. Limited time prevented inclusion of a number of most interesting features, some of which they kindly added. It is noteworthy that an excellent surgeon, Dr. Lanman, reported 40 of these cases in 1939, all of which were fatal. The picture has changed quite a hit in the intervening years to where the survival rate now is up to 65 per cent, as Dr. Hogg said.

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Sore Tongue
Diagnostic and Therapeutic Aspects

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Structurally and functionally, the tongue is an important muscular organ. It is covered by mucous membrane containing papillae, mucous glands and lymph follicles. The sense of taste is mediated by the sense organs in the tongue. Taste buds consisting of groups of epithelial cells are found in the mucosa covering the tongue, especially on its tip, edges and posterior third.

The lingual epithelium may pass through hyperplastic or atrophic changes depending on the cause. The tongue itself is subject to the sort of inflammatory states commonly observed in scarlet fever, tuberculosis and syphilis. The tongue may be attacked by neoplastic disease often by extension from adjacent structures.

The pale tongue suggests the presence of some form of anemia attributable to liver or iron deficiency.[1] The edematous tongue is said to suggest an allergic state, often a food allergy. The tongue may be involved in a generalized angioneurotic edema.

Alterations of the tongue may be varied and of local significance only, or associated with, or the local manifestation of, generalized diseases.

Examination of the Tongue-Anomalies

By dryness of the tongue a generalized state of dehydration is suspected and detected. By its coating a clue to deficiency disorders and infectious diseases is obtained. Several forms of glossitis are known to be caused directly, or indirectly, by a lack of certain vitamins in the body. The best example of this is the tongue in pellagra. Certain forms of glossitis are observed in association with oral diseases. As previously intimated, neoplastic processes may extend from one organ to another.

Anomalies of the tongue are of considerable significance. In the newborn one may encounter developmental irregularities such as ankyloglossia, or tongue tie, and bifid tongue. Absence of papillae gives the tongue a glazed appearance. The presence of more or less permanent fissures characterizes the scrotal tongue.

The large tongue, macroglossia, is a true hypertrophy, which may be associated with cretinism and mongolism, and occasionally is caused by a congenital lymphangioma. Enlargement of the tongue may be acquired in myxedema and acromegaly. Since macroglossia frequently accompanies generalized amyloidosis, this pathologic syndrome always should be considered when the tongue is enlarged.[2]

Other developmental anomalies which should be noted are lingual thyroid, thryoglossal cyst, and so-called glossitis rhombica mediana.

Lingual thyroid, a symptomless developmental anomaly, when enlarged may produce pressure on the respiratory organs and thus interfere with swallowing and speech. At or during middle life the potentiality of malignant development must be seriously considered.

A persistent thyroglossal duct may lead to the development of a cyst at the base of the tongue. It is then known as thyroglossal cyst. The question often raised is whether this should be considered as an anomaly of the tongue or of the thyroid.

Glossitis rhombica mediana, better known as median rhomboid glossitis, is a condition in which the midline of the tongue presents a reddened and roughened rhomboidal-shaped area devoid of papillae. It has nonuniform features and is of little significance, producing practically no subjective symptoms.

Injuries of the Tongue

Wounds of the tongue are caused during falls by objects held in the mouth. Biting of the tongue, like that occurring during convulsive seizures, during general anesthesia, during tonsillectomy and occasionally during the course of traffic accidents, may result in peculiar types of injuries. The persistent irritation of irregular or

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sharp teeth or faulty-fitting dentures is responsible for not a few tongue injuries. Insect bites produce an edema and swelling of the tongue.

Dental instrumentation or operative procedures may result in bruising of the tongue. To these causes should be added scalding from hot food or drinks and the accidental ingestion of lye, phenol and other caustic preparations.

Diseases of the Lingual Epithelium

LEUKOPLAKIA. — This disease may involve the mucous membrane structure of any organ of the body, and the tongue is no exception. Persistent irritation is held to be the main etiologic factor. Characteristically, one observes irregular, firm whitish or grayish patches, either alone or in association with other forms of glossitis, more especially syphilis. The lesions, which are commonly considered as precancerous, have been classified in three types, namely, the smooth (tessellated), the raised (plaque), and the verrucous (papillomatous).[3] Bauer[4] pointed out that the leukoplakic patches on the tongue become warty and leathery earlier than those appearing in other areas of the oral cavity. The leukoplakic tongue has come to be known as "smoker's tongue," though other sources of persistent irritation than tobacco may be at fault.

Grossly, the color and consistency aid in identifying the lesions. Microscopically, there is seen a simple thickening of the rete malpighii with a fully developed stratum corneum, such as is found on the skin.[5]

Diagnostically, early biopsy is essential, not only for avoidance of error, but also for detection of coexisting diseases such as syphilis or tuberculosis. Treatment should embrace elimination of all forms of irritation and eradication of the lesion itself by surgical excision or electrodesiccation. For well localized lesions, radiation therapy has proved effective.[6, 7]

GEOGRAPHIC TONGUE. — Erythema migrans, or wandering rash of the tongue, is a recurring inflammatory disease of the tongue characterized by superficial, circinate lesions which run an acute course, disappear in one area and regenerate in another, "to form bizarre geographic pattern." The patches have red centers and a yellowish border presenting a peculiar appearance like the pattern of a map. For this reason the term "geographic tongue" has been applied.

The cause of this lingual entity remains obscure. The diagnosis is aided by the characteristic migratory reformation of the patches. Treatment entails removal of all forms of irritation, especially smoking, and upbuilding of the patient's general physical state. The lesions themselves sometimes disappear with improvement of oral hygiene, but if they persist, chemical cauterization merits trial.

SCROTAL TONGUE. — The furrowed tongue, lingua plicata, has been labeled scrotal tongue because of its similarity of appearance to the tissues of the scrotum. The grooves are definite in arrangement, while the size of the tongue is considerably increased beyond the average normal. Scrotal tongue commonly coexists with macroglossia, geographic tongue and some hormonal deficiency states.

The furrowed lesions are irreversible. Good oral hygiene is an obvious necessity. Frequent removal and cleansing of food particles deposited in the deeper furrows are essential measures.

BLACK HAIRY TONGUE. — This is a distinct clinical entity attributable to a superficial infection with plant-producing bacteria, molds or fungi accompanied by certain morphologic changes of the tongue coating.[8] Some authorities have ascribed this particular tongue entity to a yeast, Cryptococcus lingual pilosae, in the presence of an acid condition of the mouth.

Jeghers[9] claimed that black hairy tongue results from hypertrophy and elongation of the filiform papillae of all or a portion of the medial dorsum of the tongue. In his opinion, the color depends on staining of the papillae and may be brownish, bluish or black; the last when the fungus, Penicillium mucor niger, is present on the filiform papillae.

Black hairy tongue is most commonly observed in debilitated elderly persons in association with infections in the oropharynx, larynx and accessory sinuses, or with some type of neoplastic growth involving these structures.[10] When the involved area over the circumvallate papillae is brushed from before backward, it presents the appearance of wet animal fur.

The association of black hairy tongue with penicillin therapy has recently been noted and reported by several clinicians.[11, 12] In one instance, the route of administration of the penicillin was by aerosol, in another by lozenges, and in still another by the conventional method, intramuscular injection.

Treatment of black hairy tongue consists of painting the area with trichloracetic acid in 25

to 50 per cent solution to effect exfoliation of the furred mass.[13] This procedure may have to be repeated one or more times. If the use of escharotics is contraindicated, the elongated papillae may be cut off, or removed by swabbing the tongue with 10 per cent salicylic acid solution. Hydrogen peroxide mouth washes, used two to three times daily, aid in the exfoliative process and in the maintenance of good oral hygiene. Gum chewing also helps to keep the mouth in a hygienic state.

Black hairy tongue is not a deficiency disease, and therefore vitamins are of no therapeutic benefit. According to Saunders,[13] the lingual process is attributable to a metaplasia and is not caused by bacteria or fungi. Consequently, local or systemic therapy is without permanent avail. This writer contended that the patient can keep the mass smaller and less noticeable by daily scrubbing with a stiff tooth brush. In the large majority of patients, discoloration of the tongue caused by penicillin therapy can be reversed by interrupting administration of the drug.[11]

Inflammatory Diseases

Glossitis implies an inflammation of the tongue irrespective of causation. The inflammation may exist independent of other diseases, or it may be secondary to or associated with diseases in other parts of the body. A glossitis may be produced by trauma, or it may result from certain nutritional deficiencies.

The following types of glossitis will be considered: pellagrous, riboflavin deficiency, Hunter's, Moeller's, and atrophic.

Pellagrous Glossitis. — Pellagra itself is a nutritional disease in which deficiency of the B complex plays the dominant role. Glossitis is a frequent and often a severe symptom of pellagra.

The tongue exhibits redness, swelling and engorged papillae. Pain is a relative symptom. Atrophic changes and ulceration sometimes obscure the actual process. Salivation is a constant annoying complaint. During active pellagra the tongue is often swollen and tremulous, sometimes cyanotic.[14]

Despite the availability of a specific remedy for pellagrous glossitis, in severe cases considerable difficulty is experienced in bringing about a normal tongue. Because the requirement of nicotinic acid varies in different persons, the dosage of this drug has to be arrived at by trial and error. Although as much as 1 Gm. daily has been administered in severe situations without hazardous consequences, as large a dose as this seldom should be required. It is frequently necessary to combine nicotinic acid with thiamine and with other vitamins before a favorable result is attained. A good diet containing all the B complex components is the ideal measure.

Riboflavin Deficiency Glossitis. — The tongue appears magenta or purplish red, frequently fissured, and with large and flattened papillae. This characteristic picture aids in the diagnosis.

Jeghers[9] offered the following explanation for the color change in riboflavin deficiency glossitis. "Capillary dilatation and proliferation are prominent features in aribоflavinosis and undoubtedly take place in the mucosal portion of the papillae. If the capillaries are dilated, one may postulate that the circulation of red corpuscles through them may be slowed. The overlying epithelium is not desquamated but thinned and perhaps edematous. These dilated capillaries, with their stagnant blood flow seen through the changed epithelium, give the resultant magenta color of the tongue. The rapid blanching of the tongue following riboflavin therapy further supports this explanation. The normal tongue in contrast has a pinkish-white color because the underlying capillary loops of the mucosal portion of the papillae are covered by a partially opaque stratified epithelium."

Hunter's or Moeller's Glossitis. — Whether Hunter's glossitis and Moeller's glossitis refer to one and the same condition remains questionable. Certain symptoms characterize each of these lingual affections, though the variations are not extreme.

Hunter's glossitis refers to the glossitis sometimes observed in pernicious anemia. Eventual destruction of the atrophied papillae is probably responsible for the pronouncedly reddened appearance of the tongue. Pain and burning are aggravated by irritating foods. Absence of the so-called "gastric intrinsic factor" may be the cause of the glossitis in pernicious anemia.[15]

Moeller's glossitis may be related to a deficiency state.[9] In some quarters, allergy to drugs or foods has been held as one of the responsible factors.[16] The course of Moeller's glossitis is a protracted one with remissions and exacerbations. The lingual process is often confounded with the glossitis of tertiary syphilis, pellagra and pernicious anemia.

Treatment embraces elimination of all irritants, good oral hygiene and regulation of the diet. Systemic diseases should be excluded. The administration of vitamin B complex seems warranted on the basis of an underlying deficiency state. Schieve and Rundles[17] found that B_{12} (0.01 to 0.05 mg.) by injection relieved pain and mucosal atrophy of the tongue in persons suffering from pernicious anemia.

Atrophic Glossitis. — The tongue appears dry, parched, red and smooth. In the course of the process, desquamation of the filiform papillae takes place. Since atrophic glossitis is merely a symptom, the underlying disease should be sought and treated. Empirically, vitamin therapy, and in some instances liver therapy, seem indicated on the basis of effective trials in some persons.

Burning Tongue

The burning sensation of the tongue may be attributable to a local process, a nutritional deficiency, or to some systemic disorders. Clinically, no special findings are demonstrable. According to Burket,[8] burning tongue represents a symptom complex which may arise from a number of factors, among which local exciting or aggravating causes are important. It may be a true neuralgia of the lingual branch of the fifth nerve, or it may be associated with disturbances of gastric secretion or psychoneurotic changes.[9]

Treatment is unsatisfactory, though on an empiric basis the administration of vitamin B complex occasionally has proved helpful. Cold antiseptic mouth washes and gum chewing afford relief to some patients.

Scarlet Fever Tongue. — The "strawberry tongue" occurs often enough to represent a characteristic feature of scarlet fever. Toomey[18] stated that the tongue is "strawberry-like" only at first, but that it changes to "raspberry-like" as the disease progresses. This is an important point in the more accurate description of this lingual process. As the coating disappears, the hypertrophied fungiform papillae project through what remains of the grayish coated background. The tongue and pharynx are usually involved simultaneously.

Ulcerations of the Tongue

Under the classification of lingual lesions are included the simple type, the tuberculous ulcer, the syphilitic ulcer and the carcinomatous ulcer.

Persistent irritation of the tongue may give rise to an indurated lesion, a simple ulcer. Lymphatic enlargement associated with such a lesion disappears when the ulcer is healed. The irritation must be eliminated. Cauterization of a lesion of the tongue is not recommended unless there is substantial proof that such lesion is benign.

A tuberculous ulcer of the tongue is observed most often in patients with advanced pulmonary tuberculosis. Ulceration is probably caused by autoinfection from the sputum. The clinical symptoms are pain, burning, dysphagia and, secondarily, debility and inanition. The prognosis is poor. Treatment affords only temporary relief. Cauterization with chromic or lactic acid occasionally serves as a local means of controlling the process. Streptomycin therapy now affords a greater optimism than formerly employed measures because of its potentially favorable influence on the pulmonary as well as on the lingual process.

Syphilitic ulcers of the tongue occur as multiple symmetric lesions with undermined edges. Bauer[4] stated that chancre of the apex of the tongue is found in 1 to 7 per cent of acquired extragenital syphilis. "The characteristic interstitial glossitis causes a smooth atrophy of the papillae and may lead to leukoplakia." According to Bell,[5] gummas in the tongue may result in induration, ulcers, or deep scars.

Local treatment of syphilitic ulcers is to be discouraged. The underlying disease must be attacked by an intensive antisyphilitic regimen.

Carcinomatous ulcers of the tongue are relatively common after the fifth or sixth decades of life. They constitute 0.7 per cent of all malignant neoplasms, 80 per cent occurring in males.

Carcinomatous ulcers have long been known to develop in the presence of other conditions. Lesions of the posterior part of the tongue are clinically silent for longer periods than those of the anterior part.

The presence of any chronic erosion, fissure, ulcer, or tumor involving the tongue or the floor of the mouth should evoke suspicion of malignant invasion. The ultimate conclusive diagnosis, of course, is made by biopsy. Treatment consists of surgery, electrosurgery, intraoral roentgen therapy, radium plaques, interstitial implantation of radium or radon, singly or in combination. The objective is eradication of the lethal disease without regard for resulting deformity or disability.

Lingual Varix. — Varicosities of the lingual veins on the base of the tongue are occasionally encountered in middle-aged persons. In most patients there is no apparent cause for the con-

dition. Irritation from excessive smoking and poor oral hygiene are likely etiologic factors. Lingual varices have been found to be associated with certain systemic diseases, like the blood dyscrasias, and also with vitamin deficiencies.

Although the symptomatology varies in different persons, there are uniformly present a sensation of foreign body in the mouth and pharynx, and hypersalivation. Indirect laryngoscopy aids in revealing the pathologic process.

No treatment is indicated unless the symptoms become annoying. Only then should the varices be cauterized or electrodesiccated. With either procedure caution must be exercised lest a vein be opened causing bleeding sometimes difficult to control.

Comment and Conclusions

Sore tongue, like sore mouth and sore throat, is a common complaint. The pathologic process may vary from a simple lesion to one of malignant proportions. Changes in the color of the tongue may develop and have no clinical significance. On the other hand, these changes may indicate mild or serious underlying systemic disease or a nutritional deficiency, or both. Since antibiotic therapy has come into general use, mucous membrane reactions in the oral cavity have been common experience.

In every case of sore tongue a prompt diagnosis is imperative. Palliative or temporizing measures should not be instituted until a conclusive diagnosis has been made. The potentiality of syphilis, tuberculosis or cancer, or combinations of these, in lesions of the tongue must not be minimized. Procrastination in performing laboratory tests and biopsy can lead only to disastrous consequences because delayed therapy too frequently proves futile.

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Discussion

Dr. J. Brown Farrior, Tampa: My associate, Dr. Richard A. Bagby, and I want to stress two points in regard to lesions of the tongue and to show a few selected cases.

First, we desire to emphasize the value of palpation of the dorsum of the tongue whenever there is a history suggestive of carcinoma. A mirror examination may show little or no change in the dorsum of the tongue whereas palpation will reveal induration which might be a carcinoma. This addition to our examination was responsible for the early diagnosis in one of the cases which we will present today. Palpation of the mouth and pharynx has become a routine part of our cancer examination.

Secondly, we want to stress what we have called the "Florida test." In our cases of carcinoma of the tongue and pharynx there has been one rather constant point in the history. The patients almost always complain of difficulty in swallowing citrus juice. We have observed this history so frequently that whenever a patient states, "Orange juice burns," we conduct the most thorough examination possible to rule out carcinoma. We have, with some facetiousness, called it the "Florida test." As Florida citrus juices are consumed throughout the United States, the symptom might well be stressed to physicians in general and to the public.

Case 1. — The patient in this case presented an apparently mild superficial ulceration of the left side of the tongue and floor of the mouth. There was no deep induration. Without a biopsy, the lesion might well have been mistaken for any of the nonspecific types of glossitis. Histopathologic examination proved it to be a mucoepidermoid carcinoma. This necessitated a suprahyoid block resection of the floor of the mouth. The incision was carried from the tip of the mastoid over the hyoid bone to the tip of the chin. The carcinoma was removed en bloc including the hyoglossus muscle, mylohyoid muscle, submaxillary gland and inner periosteum of the mandible. In this low grade type of carcinoma, the prognosis should be excellent.

Case 2. — In this case the patient complained of persistent soreness in the back of the tongue for about one month. More detailed questioning revealed that there had been some mild dysphagia for eight months. Palpation revealed an extensive mass extending from the base of the right tonsil to the medial half of the left lingual tonsil. The lesion involved the entire area from the anterior surface of the epiglottis to the posterior half of the tongue. A biopsy was performed, and histopathologic examination proved this to be another mucoepidermoid carcinoma. Palpation would have resulted in a much earlier diagnosis of this lesion. Because of the absence of cervical metastases and because of the low grade of malignancy, we performed a rather heroic resection which shows every indication of saving this patient's life.

The resection included the top half of the larynx, the posterior two thirds of the tongue, all structures medial to the left hyoglossus muscle and the right tonsil, and the right stylohyoid and hyoglossus muscles.

Although it was necessary to remove the right hypoglossal nerve, this patient has been able to swallow and breathe through normal channels, and every indication is that she is going to continue to do so.

Case 3. — This case taught us the importance of palpation of the dorsum of the tongue. The patient was a typical nervous middle-aged woman presenting a history suggestive of globus. We treated her as such for two visits; then, fortunately, Dr. Bagby palpated the dorsum of the tongue, finding an area of induration at the base of the left tonsil. This looked like a lingual tonsil; however, biopsy was performed, and histopathologic examination proved it to be carcinoma. The radiologist did not give us much encouragement in the treatment of this type of lesion with deep roentgen therapy. We, therefore, performed a Commando operation with complete cervical resection, section of the center of the mandible and resection of the left half of the dorsum of the tongue and pharynx. Pathologic study of the tissue revealed that cervical metastases had already developed in this small lesion. About three months later, there developed a node on the right side of the neck, and we performed a cervical resection on that side. The patient has now been cancer-free for nine months.

In this high grade type of malignant disease, the absence of recurrence for this period gives her a 75 per cent or better possibility of a lasting cure. She enjoys the social life and responsibilities of the wife of a law professor. Photographs show the minimal scarring and indicate something of the excellent morale of this patient.

In closing, again we want to stress the value of palpation of the mouth and pharynx and, with some facetiousness, to mention the "Florida test."

Problems of a Tumor Clinic Director

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Whenever a group of doctors, a county medical society, or a hospital staff decides to organize a tumor clinic or a cancer clinic, someone finds his problems are just beginning, whether he is to be the director of the clinic or whether he is just the chairman of the committee for studying the proposals for the authorization of the clinic. I can speak with a little authority, since for approximately two years prior to the organization of our clinic I was chairman of the study committee to determine the method of clinic organization that would be satisfactory to the entire staff of doctors who would be operating the clinic, and also that would make it an acceptable one for the Accrediting Bureau of the American College of Surgeons.

At the time of our organization, there was much talk about cancer detection centers, and whether we were going to have merely a detection center, a diagnostic center, or a combination diagnostic and treatment center. It was the thought of our committee that a detection center was a needless waste of time and effort, for each and every individual doctor's office should be a cancer detection center. It was believed that if we were to have a clinic, it should be a diagnostic and treatment center. It was also thought that we should attempt to meet the requirements of the American College of Surgeons from the start. We were unable at the onset of our studies to meet the requirements of the American College of Surgeons and had to wait until we had a pathologist and a radiologist before we could really get under way. We presented these recommendations to the staff, which accepted them and named me as the acting director to proceed with the further organization.

The next problem that came up at that time was whether to call our clinic a cancer clinic or a tumor clinic. This is not, one would think, ordinarily too important; however, cancer strikes a great deal of terror into many hearts and would deter some persons from seeking aid until too late. Tumor does not, and it was felt that "tumor" would be the most advisable term since people would fear if they came to a cancer clinic they would have the disease just by the nature of the word.

Location

The next problem was the location, or where the clinic would be held. This problem has been rather easily solved so far, but in the future will present difficulties. At the outset, we had available space in our new hospital; however, the hospital census is growing and at some future date we are going to be crowded for space and do not know how this problem will be met. The hospital is the most feasible place for the clinic in that one can get the doctors to the conferences at the hospital whereas it would be difficult at another place. The next detail was the time of holding the conferences, which is an exceedingly important matter. One must pick a time which will not interfere with the doctors' practices and still be suitable for the patients to arrive at the clinic to be

Director, Leon County Tumor Clinic.
Read before the Florida Health Officers' Society, Eighth Annual Meeting, Hollywood, April 26, 1953.

seen and examined. After many conferences with the original committee and the hospital staff, it was decided that the best time to have the clinic was early in the morning, once a week. State Board of Health regulations require an 80 per cent attendance of staff members at the clinic; so it was agreed with the staff that surgery would not be posted during the clinic hour so that all could attend. On each Thursday we hold our clinic from 8 to 9 a.m., and the posting of surgery begins at 9 a.m. except for emergencies and tonsillectomies. This is not a rule of the hospital, but the doctors have voluntarily agreed to this schedule.

Financing

The clinic is financed jointly by the State Board of Health and the American Cancer Society. The State Board of Health pays for the hospitalization, roentgenograms and laboratory work, and the services of a full time secretary; the American Cancer Society pays for the expendable medical items, for a part time secretary, and the necessary office expenses. Also, the American Cancer Society assists in paying transportation for needy patients to the clinic, and room and board when indicated for a stay in town during a course of treatment. Local civic organizations have also helped meet this expense. Initially, the State Board of Health purchased for the clinic the office equipment and numerous special surgical instruments, as well as some of the equipment needed in the examination and treatment of the patients. This plan would seem to take care of all of the needs of a clinic; however, there are items that we are unable to get through the State Board of Health. We were fortunate in the organization of the clinic initially in that the State Board of Health was paying physicians' fees, and the physicians decided that since these were charity cases, they did not wish to benefit financially and they would turn in to the clinic the funds paid by the state. These funds were used to purchase additional equipment for the clinic, which has been a great asset to us. Since the physicians' fees have been abandoned, this fund has been wiped out, and we shall have to continue as best we can in the future.

Another question that came up was the rental of radium, there being none in the hospital. An agreement was worked out with the hospital and the State Board of Health that each pay half of the rent on the radium that is at present available. This is available for both clinic and private patients, as is the other equipment purchased for the clinic.

Importance of Secretary

The most important position to be filled in the organization and operation of the clinic is that of secretary. The most important problem, therefore, is the employment of a suitable secretary. I might add at this point that a secretary who is suitable for this place is greatly underpaid. This person can either make or break a clinic, and I want to say here that the success of our clinic was due largely to our good fortune in securing a most excellent secretary from the beginning. This job is classified as a Stenographer III under the State Merit System, requirements for which are a minimum of three years' experience, and the ability to take short hand at 96 words a minute and type at 50 words a minute. Beginning salary in the State Board of Health for this rank is $200 a month, and it is hard to get this raised.

The secretary, however, must be more of an executive than a secretary, because it takes executive ability to carry out the many duties required of a clinic secretary, and to handle the relationships between numerous doctors. With the proper secretary, 90 per cent of the problems are solved because she can handle them herself. Her duties, of course, are multiple. She must keep all of the records of the clinic so that they will be acceptable to the American College of Surgeons. This task includes individual files for each patient with past and present history, and current treatment and follow-up; an accession register of patients with vital statistics and diagnosis; a cross index file by name and by disease, which requires ability to use the Standard Nomenclature of Diseases.

She must take the family and past history of each patient, as well as a brief summary of the complaint, so that the doctor will be saved time; however, this assistance does not obviate the necessity of his going over the present illness himself because a secretary cannot get all of the history that is frequently necessary as she will not know how to question the patient. Conversely, he will find in the history she obtains much information that the patient will not tell the doctor. She must make the assignment of the individual patients to the different doctors on the staff for diagnostic studies and surgery, doing so in rotation so that no one will be overburdened and there will be an even distribution of all cases.

She must keep a check on the patients' admissions to the hospital and see that they do not overstay their authorized time, and if for some reason a surgical procedure or the patient's condition requires a longer stay, see that requisition will be made to the state for additional time. She must keep the financial record of the moneys received and spent, prepare a budget to send to the American Cancer Society to secure funds by which we will operate, and also must see that we live relatively within our budget.

She must plan appointments with patients to insure that no more come to a clinic session than can be adequately examined or treated during the session. She must maintain a follow-up of patients through the County Health Departments when for some reason they do not return for check-ups, and must arrange for transportation money and living expenses for patients when necessary. She must prepare reports of findings and treatment to the referring private physicians. She must have a surgeon assigned to each clinic session to perform any biopsies that may be needed, and see that patients are followed afterward. She must make sure that all items needed for examination and biopsy are available for each clinic session, and that sufficient nurses or aides are available to insure the smooth operation of each clinic session. She must photograph the malignant lesions, both before and after treatment, including surgical specimens on request.

While not actually a part of the job, a good secretary will keep up with new professional films when issued and arrange to show them to the group. She will also be available to show films and give talks to lay groups on the general subject of cancer on request of local civic organizations and the University. The assistance we have received from local organizations, both financial and in service to patients, might not have been secured without this service by the secretary.

The relations of the director with the staff doctors should present little if any problem because of a mutual understanding at the organization of the clinic, and if the secretary has carried out her duties as outlined, 90 per cent of the problems that one would encounter are solved. This relationship must necessarily also be a problem with the secretary as well as the director; for example, sometimes a doctor refuses to take a case, whether for a legitimate reason or not, and this situation requires a great deal of tact on the part of the secretary.

Referrals

All patients are referred by a private physician or through a county health officer, and those referred by a private physician must have the application processed through the Health Department office. Here the greatest difficulty seems to be that many of our health officers have several counties and are entirely too busy to screen properly some of these cases. Furthermore, the health officer in some counties is the only doctor available locally, and he is hard put to it to stay within the realm of public health and the practice of preventive medicine. Because of the fact that he does not have sufficient time for all this, he is sometimes prone to make application for state aid to patients who, to us who are treating cancer patients and are in active practice, are obviously not suffering from malignant disease or a potential malignant condition. Were we, however, trained in the same basic background and placed in the same position, we would probably do likewise. We can help each other a great deal if, when referring patients, or if, when we are prone to criticize the health officers, we would turn ourselves around and place ourselves in the other fellow's shoes; we might be a bit more tolerant of the position and the case.

Another problem that comes in our relationships with the health officers in some instances is that patients will be sent in to the clinic who are not medically indigent and should be referred to a private physician. I know this matter is most difficult to handle because we have no social service worker to determine the means of some of these patients, but we frequently have patients come who should have been sent to a private physician for their treatment. There are many patients, with skin carcinoma particularly, who are not indigent for the care and treatment of this condition, whereas were they to have a carcinoma of the stomach, breast or cervix or other malignant lesion requiring a long hospitalization, roentgenograms and extensive studies and a large surgical fee, they would be medically indigent. When they can pay their own way in the cases in which treatment is not extensive, they should be expected to do so.

Another similar problem along that line, and I do not know the solution, but we all should be thinking of it, is that we will have patients who are in themselves medically indigent, yet they have children who are well able to take care of their parents' medical needs for treatment of any

malignant disease. We had one case particularly that I recall, assigned to one of our doctors, and he was angry about it and justly so. This patient was admitted to the clinic, and through no fault of the referring physician, but this patient's family came from Miami to Tallahassee by plane four or five times during his illness, demanded that he have special nurses, and insisted that he be placed in a private room. They were especially demanding also of the doctor who was caring for the patient for nothing, even taking time in the office to discuss the case. They later took the patient out of the hospital and placed him in the care of a private physician in Miami.

These same problems that I have applied to the health officers also apply to the referring private physicians in other counties. There are a few who are not clinic patients who have been to see one doctor who will refuse to send them to the clinic, and they go to the doctor next door or in the adjoining town who will file papers for them to be sent to the clinic. There are also some problems with regard to individual patients in that they will think that there is something magic in the words "tumor clinic" and that they would get some magic benefit that they could not get from a private physician. I have had patients come into my office wanting to go through the Tumor Clinic, but they had Blue Shield, Blue Cross or other insurance which would pay for their entire treatment. When they were told that when they go through the clinic they would merely be assigned to a physician for work-up and then presentation for conference for type of treatment, they were perfectly happy to go along and see a private physician.

There is also the doctor who sees patients with a definite malignant lesion he is unable to treat and who merely refers them to the Tumor Clinic regardless of ability to pay. Some of these people do not realize that the clinic is for treatment of indigents; they have to be discharged and are referred to some private physician for treatment. This situation can and has caused a great deal of embarrassment to physician, patient and clinic director. Any physician in the area served by the clinic may refer a patient who presents a difficult diagnostic problem when the possibility of the presence of a malignant lesion is suspected, but those not medically indigent are expected to pay the cost incidental to making a diagnosis and should be referred to a local private physician with a request for clinic consultation if indicated. These patients are then referred back to their private physicians with recommendations for treatment.

General Problems

Some general problems that have come up come to mind. The State Board of Health will pay for treatment only if there is reasonable hope of cure, or in terminal cases if palliative therapy offers relief from pain or gives hope of prolonging life substantially. Patients are sent to us at times who have had adequate work-up and treatment by some private doctor or some approved clinic, and then when they are in the terminal stage are sent to us for treatment. These patients expect to be cured or to have terminal hospitalization by the state. Also, patients that have been treated in our clinic and have reached the terminal stage expect to be cared for by the clinic during the last stages of their illnesses.

There is also the problem that every doctor who specializes encounters in his office, that of the patient who comes in for treatment of a malignant lesion and then wants everything else in the book, too.

A constant problem has been the difficulty in securing an adequate history of the patient's condition from the referring physician, whether in private practice or in the health department. The staff doctors frequently complain of the inadequacy of the history presented, and we feel that since we are taking care of indigent patients of the other doctor without charge, it should be the duty of the referring doctor and a courtesy to the clinic to send in an adequate history. The doctor referring the patient can often obtain more information than we can. It often makes a difference in judging the amount of time necessary to make a diagnosis, and the amount and kind of studies needed, and when one considers that we must have prior authorization from the state for these studies, he can realize the value of an adequate medical history.

We have had some trying problems with physicians in outlying areas who in emergency cases send the patient to the clinic. One I recall had a diagnosis of advanced rectal carcinoma and was sent in for emergency treatment; the patient had thrombosed hemorrhoids. There have been instances in which the referring physician would phone my office collect to secure a clinic appointment, placing this financial responsibility on my personal office expense.

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Cat Scratch Disease

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Cat scratch fever or lymphorecticulosis is a new disease entity which has come to light in the last two years. The disease is often due to the scratch or bite of a cat. It may also be brought on by a prick of a contaminated thorn or bush or contact with other animals.[1]

The symptoms of the disease usually are ushered in by malaise and fever, and almost always lymphadenopathy and lymphadenitis are present. Involvement of the regional lymph nodes may be so severe as to proceed to suppuration. There may or may not be a lesion of the involved area; the lesion sometimes assumes the characteristics of the tularemia sore. It is possible, however, for the original site of inoculation not to be exhibited at all, though most frequently multiple or single scratch marks can be visualized by the time the patient presents himself to the physician. The course of the disease is insidious and usually proceeds to full tumescence before the patient recognizes something is wrong or discovers an enlarged and tender lymph gland or a persistent ulcer or sore, which does not seem to heal rapidly. Usually the general physical findings are essentially within normal limits except for the involved area. The temperature ranges from normal to 102 F. and above. The patient is not extremely ill, but experiences lassitude, anorexia and sometimes abdominal or joint pains, as observed in my cases. The laboratory findings in the cases observed in my area were negative in all instances, heterophil and other agglutinations being within normal limits and Kahn and V.D.R.L. examinations giving negative reactions.

Dr. Franklin M. Hanger[2] and Dr. Harry M. Rose[2] in 1945 prepared an antigen from aspirated pus from a suppurative regional adenitis. Injected intradermally, this antigen gave an intense tuberculin-like reaction both in Hanger, who suffered from the disease, and in patients of Foshay.[2]

Greer and Keefer[3] were the first to publish a case in America in 1951.

The involved glands did not proceed to suppuration in the cases presented here. It has been reported in the literature, however, that complete breakdown with suppuration may occur.[3]

This disease is probably of virus origin, but the virus has not been isolated as yet. Mollaret,[2] in 1950 and 1951, collected many additional cases, found a serologic relationship between this illness and those diseases due to the lymphogranuloma venereum-psittacosis group of viruses, transmitted the disease to one volunteer and to monkeys, and described inclusion bodies in the cells of primary lesions and affected lymph nodes.

Cat scratch disease or lymphorecticulosis usually continues for several weeks to several months, and in 1 case reported here the disease progressed for several months. The use of the antibiotics has proved futile in most cases, but in my experience there seemed to be some response to Aureomycin therapy. The cases in the present series were all observed within the city limits of St. Augustine. It is reasonable to believe, however, that many similar cases have occurred throughout the state, but because of the newness of the disease have not been recognized and have been diagnosed probably as regional lymphadenopathy or regional lymphadenitis.

The initial lesions observed in 3 cases of my series were cat scratches, and in the fourth a small tularemia-like sore and also cat scratches on the hand. The sore was in the form of a raised, vermilion, dusky-red, crater-like ulcer with a slight scab, but no pus could be expressed.

Daniels and MacMurray[2] reported definite intervals from the time of the initial lesion to the onset of symptoms with slight variations. In my experience, however, it was difficult for the patients to recall when they originally had been scratched, as most of them were constantly associated with the cats involved. The lymph nodes most involved were the axillary in 3 cases and in 1 case the right epitrochlear node. Evidences of lymphangitis were not observed. Apparently it is

not necessary for a definite scratch or bite to transmit the organism. Daniels and MacMurray[2] reported cases in which 1 patient sniffed cushions contaminated with cat urine, another was pricked by a porcupine quill, a third handled wild rabbits, and a fourth was scratched by a splinter on a meat crate. They also stated that the infecting animals transmit the disease probably only passively since they have negative intradermal reactions to cat scratch antigen.

All of the patients in my series presented practically the same symptoms: malaise, anorexia, nausea, weakness, lassitude, aching, chills, headache and in 1 case acute abdominal pain. The elevation of temperature was consistent throughout, not exceeding 102 F. as a rule. Antigen was obtained from Dr. Worth B. Daniels of Washington, D. C., and in the 4 cases tests were made by intradermal inoculation of the specific antigen. The skin test was the one originated by Hanger and Rose, utilizing the principle of the original Frei test. Pus is diluted, 1 part to 5 parts, with sterile isotonic sodium chloride solution and heated to 56 C. for one hour on two successive days. The test is performed by injecting 0.1 ml. of the material intradermally and is read in 48 hours, when the reaction is maximal. A positive reaction is comparable with a tuberculin reaction and consists of a raised indurated papule measuring 0.5 to 1.0 cm. in diameter surrounded by an erythematous areola measuring 3 to 5 cm. or more in diameter. Rarely the injection of antigen activates the primary lesion and may be associated with a rise in temperature.

The French investigators have encountered no false positive reactions.[4] Sensitivity to the antigen is persistent, lasting over two years in one of my cases.

Family outbreaks of the disease have been described.[4] These small epidemics have centered around the family cat, as in 2 of the cases presented here.

The pathologic changes of the lymph nodes include hyperplasia of reticuloendothelial cells early in the disease, followed by the development of focal granulomas with suppurative processes and necrosis.[2]

The problem which confronts one in dealing with this disorder is that of prevention, as the virus is carried by the common house cat, which is found in many homes in this state.

Titlist[3] commented that as yet no work has been recorded on preventive measures to be taken and he observed that it must also be considered that owners of cats transmitting the disease may be reluctant to part with them. Daniels and MacMurray[2,4] reported that Mollaret[2] speculated that since such a disease among cats is unknown to veterinarians, since it has been impossible to transmit it to cats and since even those cats suspected of having transmitted the disease have had negative intradermal reactions, the cat probably transmits the disease only passively. He believed that one must search for the source of infection among the cat's natural victims, namely rats, mice and birds. This is an almost impossible situation. He particularly suspected that birds may play a role. His efforts to affect birds, however, have been unsuccessful.[3]

The disease known as cat scratch fever, cat scratch disease, or lymphoreticulosis, although not a fatal one, is certainly to be placed in the category of a nuisance. Although in the cases reported here the disease was not of a severe nature, in other reported cases there have been present large suppurating glands and abscesses involving surgical procedures and prolonged periods of convalescence. It is hoped that in the future in any unexplained cases of lymphadenopathy tests may be made with specific antigen and lymphoreticulosis or cat scratch fever ruled out as a routine measure.

There follows a report of the 4 cases discussed:

Report of Cases

Case 1.—C. S., a white boy aged 10, was seen at home on Oct. 20, 1952. He complained of pain in the right side of the chest and abdomen and a painful swelling in the left axilla. The temperature was 100 F. The child was lying in bed exhibiting pallor and moderate malaise and complaining of pain in the abdomen at the margin of the right upper quadrant and the left sternocostal margin. Having had none of the serious childhood diseases, he had been well all his life until one week previously when he began to experience malaise and have a low grade fever in the afternoons. He had received several scratches from the family pet, a small kitten about six to eight weeks old. Most of these scratches were confined to the left hand and forearm and all were well healed. The general physical examination gave negative results except for some tenderness in the upper portion of the abdomen. The liver and spleen were not palpated, nor were any other of the lymph nodes enlarged. The only pathologic change was a tremendous enlargement of the node in the left axilla. It was tender and about the size of a small lime with minimal erythema over the surface. The left epitrochlear node was not palpated. There was no evidence of lymphangitis on any of the surfaces of the arm or forearm. General laboratory examinations, including heterophil and other agglutinations, gave negative reactions. The white blood cell count was not elevated, and there was no change in the over-all differential count. This patient was given

Aureomycin because previous experience had shown that therapy with penicillin and sulfonamides was futile in this type of disease entity. Over the course of several weeks the axillary node decreased in size and finally approached normal size. The temperature returned to normal, and at present the child is well and shows no evidence of the disease. Attempts to obtain antigen were finally successful in August of this year, 1953, and this patient was given 0.1 ml. intradermally with the resultant red papule surrounded by a pinkish red areola, indicating a positive reaction, appearing in 48 hours.

Case 2.—G. S., a boy aged 7½, was a brother of the patient in case 1. This patient was seen in the office and complained of malaise, fever and pain in the left axilla. There was a history of occasional sore throat of a mild nature. Two weeks previously, his brother had had an attack of what was thought to be lymphoreticulosis or cat scratch fever, a large axillary node having developed following cat scratches on the left arm. This child also had played with the same cat and exhibited scratches on his left hand and arm. The physical examination was not too informative, there being no evidence of adenopathy, hepatomegaly or splenomegaly. The laboratory examinations gave no evidence of abnormality, and although the patient had a temperature of 101 F., he was apparently otherwise well. Over the dorsum of the left hand and arm there were small scratches. The left epitrochlear node was enlarged slightly and tender. There was a large axillary node at the outer margin of the pectoralis major muscle. It was about the size of a pecan and especially tender to palpation, and exhibited erythema of the skin. Aureomycin was used in treatment. The course was one of slow diminution of the fever and malaise over a period of four to six weeks. This child was skin-tested in August 1953 with a resultant papule, red and firm, about 0.5 cm. in diameter, surrounded by an erythematous areola measuring about 3 cm. in diameter, indicating a positive reaction in 48 hours.

Case 3. — G. M., a white woman aged 26, complained of malaise, persistent fever of two weeks' duration and an enlarged node on the medial surface of the left arm. There was a history of an appendectomy in childhood and the usual childhood diseases. The patient was a registered nurse who had worked in surgery for several years. At the time of this illness she had a large cat of which she was especially fond and which she used as a lap pet. On physical examination, other than malaise and a temperature of 102 F. there were no grossly abnormal findings. There was a small ulcer on the knuckle of the left hand between the second and third fingers which was punched out with a border of erythema and swelling. There were several small cat scratches on the left hand. The left epitrochlear node was enlarged to about the size of an acorn, and later to the size of a pecan. This node was particularly tender to palpation. There were no other enlarged nodes, and the liver and spleen were within normal limits. The general laboratory findings were essentially normal at this time. The course of the illness was long drawn out, lasting several months.

The patient was seen by a surgeon in New York, and soft tissue roentgenograms were made, but they showed nothing significant. She was given penicillin to no avail, and gradually over the course of several months the condition subsided although there were times when malaise and fever were most disturbing. It is unfortunate that no antigen was obtained to run specific tests. Antigen was mailed to her, and in August 1953 an intradermal injection of 0.1 ml. of this material gave a positive reaction in 48 hours, consisting of a firm, raised, central papule, 0.4 cm. in diameter, surrounded by an erythematous areola of about the same size.

Case 4. — G. F., a white boy aged 3½ years, played constantly with the family cat. On July 23, 1953, the right epitrochlear node became enlarged to the size of a large pecan, was tender and exhibited slight erythema over the overlying skin. The temperature was elevated to 102 F., and the patient experienced chills, malaise, anorexia and lassitude. There was no evidence of lymphangitis. There were multiple healed cat scratches on the right hand. The general laboratory data were within normal limits; however, a Frei test was not made because the Frei antigen was not available. A skin test, with the cat scratch antigen, was made on Aug. 8, 1953, and in 48 hours a small papule about 3 cm. in diameter, reddened and elevated, was found with a pinkish red areola of 5 cm. surrounding it.

Summary

The symptoms, etiology, pathologic manifestations, treatment and prognosis of cat scratch disease or lymphoreticulosis are discussed. Four cases of this recently recognized disease entity are reported.

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Box 100.

President's Address

Eightieth Annual Convention

First House of Delegates Meeting

Hollywood, Tuesday Morning

April 27, 1954

Malpractice and Insurance

Samuel M. Day, M.D.
Jacksonville

By accepted definition, the term "malpractice" simply means the treatment of a case by a surgeon or physician in a manner contrary to accepted rules and with injurious results.[1] The "accepted rules" or standard of practice is supposedly determined by what other reputable physicians in the community or in similar communities would or would not do in the care of similar cases.

If the justness of every malpractice claim were decided on the basis of that simple definition alone, the ethical physician would have no reason to fear malpractice suits, nor would he have to endure the ever rising premiums that are presently his lot. Were physicians always able to obtain perfect results, there would be no malpractice actions.[2] But medicine is not an exact science, and not all patients who are given medical or surgical treatment get well. Many are left with some disability or deformity, and therein may lie a cause for a patient's complaint — be it just or unjust.

Whether or not the uncured patient brings action against the doctor is often determined by his feeling toward his physician. Patients who have a feeling of friendly trust for the physician and who believe that everything possible has been done for them are not likely to sue for malpractice, even when bad results ensue. Malpractice suits often arise if the patient is resentful of some actual or fancied affront, if he believes that he has not been sufficiently closely attended, or above all, in some 50 to 80 per cent of suits, if some third person, too often another doctor, raises a doubt in his mind as to the correctness of the treatment. Too often someone unfamiliar with the details of the case casts such a reflection. It need not be conveyed by actual spoken criticism for it can be imparted simply by the raising of an eyebrow or by a frown or some slight evidence of disapproval of what has been done. Little do we doctors realize that by little innuendoes such as these we are doing great harm to ourselves as well as to our profession.

Though we doctors are the party upon whom both financial and moral responsibilities of malpractice rest, the "accepted rules" have been lifted from our hands and delegated to lay people, the legal profession and the juries and courts, for final interpretation.[1] The end result has been that even if a malpractice claim has no recognizable merit, too often we settle out of court to preclude the besmirching of our professional reputation. Are we therein misinterpreting the true reasons for having malpractice insurance? The news of suits and settlements gets around and brings many new complainants.

This problem brings several questions for our consideration.

I. Is the rise in insurance rates justified?

Certainly there has been a great increase in the loss ratio of insurance companies in Florida.

	1948-1949	1950[3]
Premiums	$113,149	$69,005
Losses	100,085	58,322
Loss ratio	88.4%	
Permissible loss ratio	47%	

This increased loss ratio has been reflected in our premium rates, a natural conclusion in insurance of any form. Florida's premiums are now fifteenth highest in the nation.[4,5] Justification for rate changes must be shown to the satisfaction of the State Insurance Department.

There are more suits than previously. During 1945 the large New York Group Plan experienced one suit or claim to every 71 doctors. During 1951 there was one suit or claim to every 30 doctors.[6]

Oddly enough, the cost of the average suit or claim has increased little. It is still less than $5,000.[6] All of us are familiar with isolated cases of higher judgments, but fortunately they are in the minority.

Secretary-Treasurer, Florida Medical Association.

Incidental costs are burdensome. These include costs of defense, settlements, unallotted claims, administration and acquisition, inspections, taxes, licenses, fees and profit and contingency factors. Apparently these are the primary cause of the recent rises in rates, and additional rises may be expected if we of organized medicine are unable to reduce the incidence of malpractice threats.

Prolonged litigation is a real factor in the cost of medical claims. It is noteworthy that medical litigations make up the great proportion of liability cases of the major insurance companies unsettled after five years, though they are only a small minority of the original liability cases.

II. What are the philosophies of insurance underwriters?

There are three:[7]

1. Group insurance with individual limits as desired.

This is the principle upon which the Florida Medical Association's master policy is based. We have been unable to obtain statements from the company which carries this policy relative to its loss ratio in this state although its rates have increased for partnerships, and for doctors using major surgery, x-ray and electric shock, along with the rates of all stock companies belonging to the National Bureau of Casualty and Surety Underwriters.[4,8]

Apparently the only advantage to such a policy is that all members are eligible for insurance, no matter how bad a risk they may be. Even this eligibility has not held true with our master policy according to some of the Association's members, namely plastic surgeons. Certainly it may be poor policy for us in any way to aid the insuring of unethical physicians by group methods, but should we not offer some help to those of our profession who are willing to undertake some of medicine's more hazardous specialties such as radiology, plastic surgery, cancer surgery and psychiatry?

2. Carefully selected individual risks with high limits to protect physicians in case of high awards. Apparently this method is the choice of many of our Association members.

3. Low limits and careful selection of individual risks without groups.

This philosophy is unique in malpractice thinking although its major proponent is perhaps the largest single insurer of physicians' liability. This company was founded 55 years ago from a group formed by physicians. It deals exclusively in medical malpractice insurance and has handled over 85,000 claims with few, if any, awards for amounts greater than the limits of its policies — $5,000 and $15,000. The emphasis is placed on rigid defense of suits rather than on high limits.[9,10] This plan is in keeping with the idea that plaintiff attorneys are much more interested in insurance money than in real or personal property of physicians. Doctors are naturally more careful with low limits. This company is very popular in many states which maintain low malpractice suit rates. With ever increasing premiums staring us in the face, maybe it will be worth while for us to look further into this philosophy.

III. It seems important for our future welfare that we recognize the growing menace of increasing suits and see what is behind it.

The something for nothing philosophy of today stimulates more suits and may bring greater jury awards.

There is a National Association of Claimants Attorneys which is active in bringing more suits. According to their NACA Journal, Vol. 10, "We do not pretend to be a neutral or vacillating Journal. We are pro-plaintiff."

There is a lack of honest and interested testimony of witnesses. Too often we doctors give honest but "prejudiced" testimonies to protect patients even though we know they are primarily in need of a "greenback poultice" and will be cured by that therapy alone. Each successful verdict against an insurance company, railroad, automobile owner or doctor brings increased public suit consciousness. Refusal of competent doctors to take time to testify properly and lack of interest in seeing a fair verdict handed down often result in unjust awards of unreasonable amounts.

The legal profession is growing rapidly. More clients are needed. Recently the Jacksonville Bar Association condemned advertising by insurance companies which said high verdicts by juries were raising the jurors own insurance premiums. This is a simple statement of reasonable fact, but it is condemned as being unfair and improperly influencing jurors. I have no armor to bear for insurance companies, but I do wish to see fairness and reason prevail.

Defense of malpractice cases is difficult and costly. Few lawyers and doctors are expert in

this field. Most of them would much prefer settlement to adequate court defense. Encouragement of a different philosophy is necessary.

IV. What can we, as individuals, do for our protection? We can do much to help ourselves[2] if we

1. Not only practice good medicine but also make sure we are able to defend our actions by proof of what was done and why.
2. Know our legal duty and fulfil it for reasonable charges.
3. Never guarantee or promise a specific result. Such is not covered by insurance of malpractice and leaves one open to suit for breach of contract.[2,11]
4. Never in any way make any remark that may be construed as an "admission" of fault. Caution nurses and assistants to take similar care, particularly in times of remorse. This amounts to an admission of guilt and may free the plaintiff from producing expert testimony.
5. Give adequate instructions and keep accurate and complete case records including copies of all letters to patients, particularly if advising them against an unwise course.
6. Use tact, as well as professional ability, in handling patients and their families. Practice good public and personal relations.
7. Be cognizant of the responsibility for the acts and omissions of employees, associates, assistants and even fellow doctors jointly caring for a patient. Each of us may be held responsible for the other if we are associated on a case.
8. Get witnessed, written consent for all lawful operations, dangerous treatments and autopsies.
9. Be careful of experimentations in the treatment of patients.
10. Advise patients of expected absence from practice and make available, or recommend, a competent substitute.
11. Use recognized diagnostic aids when even vaguely indicated, such as consultations, roentgen studies and laboratory procedures.
12. Have some knowledge of the statutes of limitations and their significance.
13. Keep inviolate all confidential information unless written permission is given to release it.
14. Never reveal that we carry professional liability insurance or the limits of it. It would be well for us to "forget" we have malpractice insurance and treat each patient as though nothing protected us from suits except our own skill and conscience.
15. Consult a legal adviser before writing a letter or making a statement in reference to a malpractice claim.
16. Keep a record of the company carrying our malpractice insurance for 25 years to be sure of proper coverage retroactive over that period. See that it is available to our heirs.
17. *Avoid destructive and unethical criticism of the work of other physicians — oral, written or implied.*

V. What can we, as a group, do for our protection? We can

1. Study the problem as others are doing, to learn the facts in our state and make them known to our membership so that appropriate action can be taken.
2. Make available expert advice. Consider the formation of a defense fund as has been done in some states, notably Washington and Pennsylvania, insuring the active backing of the medical profession and guaranteeing the close cooperation of competent physicians.
3. Inform the public as to what constitutes malpractice and how few cases of actual malpractice occur.
4. Develop a consciousness of the major degree of responsibility a person has in the maintenance of his own health.
5. Give thought to forming insurance or malpractice committees, with annually rotating members, to study each malpractice suit and see that it is carried to its proper conclusion, advising prompt settlement of all legitimate claims if the amount is not excessive; and if such is indicated, recommend remedial action against the offending member such as has been carried out successfully in Alameda County, California.[1] The idea is to pamper no case, no matter how trite, but force the

unjust case into court, if that be necessary, no matter what the expense or inconvenience to the individual doctor or insurance carrier might be, thereby discouraging the filing of trivial or unjust suits.

6. Demand strong and fearless grievance committees to hear patients' complaints. They must not be whitewash committees. They must discipline physicians who refuse to practice by accepted standards and refuse to follow ethical practices. Particularly, they must prevent collusion between patients and physicians against insurance companies, or vice versa.
7. Maintain and properly publicize emergency call systems for the benefit of the public to insure getting a doctor when one is needed. Every effort should be made to insure the continued cooperation of the participating physicians. Frequent checks may be necessary.
8. Consider underwriting our own liability insurance in a nonprofit way such as was done with hospitalization and illness insurance by Blue Cross and Blue Shield. This has been suggested by Dr. Whitman C. McConnell of St. Petersburg and others, but it is felt that these times are not conducive to initiating a plan such as group underwriting without prolonged actuarial studies.
9. Consider the formation of a medicolegal board to hold confidential hearings, determine the merit of each case and make recommendations according to findings.[12] This plan is probably too impractical for actual operation in these days in which the Golden Rule is often forgotten.
10. Promote voluntary health insurance and maintain close relations with such insurance programs to reduce physician abuses of such plans.
11. Offer through the medical society and publicize a guarantee of medical care for all, regardless of the ability to pay. Be prepared to make good on the guarantee when necessary.

Recently a representative of the American Medical Association told me that we would have little difficulty with suits if the medical doctors would adopt two practices of the osteopaths, namely, appreciate and recognize the psychosomatic ills, and be reluctant to criticize our fellow practitioners. In other words, we need only to follow our own ethics, which were established long before the founding of osteopathy. Closer cooperation of all physicians will result in fewer suits and lower premiums, and will be real insurance for happier patients and doctors.

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415 Medical Arts Building.

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P.O. Box 1018, Jacksonville, Fla.

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ABSTRACTS OF MEDICAL ARTICLES

Bladder Neck Obstruction in Females. By W. A. Van Nortwick, M.D., Robert B. McIver, M.D., and Robert J. Brown, M.D. South. M. J. 46:691-694 (July) 1953.

Noting only an occasional report of lesions of the posterior urethra in females in the current literature although such reports have been increasing during recent years, the authors believe the condition frequently is undiagnosed and that treatment is administered for other diseases over a long period of time before the true condition is recognized. It is their belief that treatment in many cases should consist of resection of the obstructing tissue.

They discuss symptoms, etiology, diagnosis and treatment. Also, they report a series of 121 cases in which resection or fulguration of the neck of the bladder was performed. The patients ranged in age from 8 months to 87 years, more than half being in the age group from 40 to 70 years.

Not only did their studies show that females of all ages are affected but also that the symptoms are extremely variable and not well correlated with the findings. The diagnosis is made chiefly by careful examination by cystourethroscopy. The operation is not without danger, and they caution that it is better to do too little and repeat the procedure later than to do too much. The postoperative care is important for the best results. In their opinion the need for repeated resections is greater than the figure indicates.

Hemorrhagic Telangiectasis: Case Report. By C. A. Fort and G. A. Winstead. J. Urol. 69:614-617 (May) 1953.

A case is reported in which nephrectomy was performed on the left side because of persistent hematuria. Hemorrhagic telangiectasis was diagnosed postoperatively by means of pathologic sections.

Continuous Enteral Feeding and Its Importance in Protein Metabolism of the Sick. By John Elliott, Sc.D., James J. Griffitts, M.D., Donald W. Smith, M.D., Geo. T. Lewis, Ph.D., and Patrick V. Ferro, B.S. South. M. J. 46:572-578 (June) 1953.

The continuing use of a constant feeding regimen applied to nutritional management in disease, previously reported by these authors, has led them to a re-examination of principles of metabolism and to a theoretic concept of feeding described in this article. After briefly reviewing the salient features of adequate nutrition, they discuss amino acid requirements in health, the inadequacy of intermittent feeding in disease, the development of a continuous feeding regimen, and adequate feeding by continuous drip.

In summary, they observe that the metabolism of the body is a continuous dynamic process; molecular complexes are constantly being synthesized and broken down. In the sick patient the requirements for the basic elements of the diet are increased and they continue day and night with slight variations due to activity. The body does not store protein, and it is therefore necessary in the face of continuously increased amino acid requirements fully to meet these requirements day and night. Only in this way can reparative processes in illness be sustained without drawing on the essential proteins of the body's plasma and tissue.

They describe a feeding regimen which can be administered continually, day and night with the minimum of care, is well tolerated and which best meets the physiologic needs of the patient whose protein requirements are increased or whose protein stores are depleted. The formula utilized and the continuous, 24 hour method of administration they present are discussed.

From Our President

Broad Horizons and Wide Margins

The demands of a modern medical and surgical practice all too often result in a concentration as well as a limitation of mental and physical activity. Bit by bit, outside and varied interests occupy less of the daily thinking and action. Shortly, the busy physician is in a groove from which he can be extricated with greater and greater difficulty. Only by effort and apparent sacrifice can the physician participate in activities outside of the office or hospital. The drive for success can easily become an obsession. The limitations of his horizon leave the physician out of touch with the lives, interests and activities of family, relatives, friends and acquaintances. The fine arts are of no interest to him; civic activities are time-consuming and boring; the leisurely enjoyment of the outdoors, the beauties of nature, the song of the bird, the fragrance of flowers, the beauty of the sunrise and the splendors of sunset become only a memory, soon forgotten.

How can such a restriction of one's horizon contribute to the full development of the physician, and the enrichment of the doctor in his field of personal service to his patients and friends? Like a book whose contents fill all pages, leaving no room at the margins for casual notes during the reading thereof, so the life with a limited horizon fails to reach its fulfilment, and cannot attain the peak of service to which it should aspire.

Do not be cramped in your outlook; laugh and be merry on occasion; be interested in those about you, and in what they are thinking and doing; have a care, unselfishly, for the ultimate good of all men, without regard for personal gain or glory; take an active part in community activities side by side with men of other professions and businesses; rub shoulders with the man in the street and get in touch with those about you.

Broaden your horizon and widen your margins. The lift to your spirit will more than compensate you for any material loss you may incur. You can take many things with you into eternity, but certainly you cannot take material things, for whose acquisition we expend an undue proportion of our time and energy.

Frederick K. Herpel



Wilburt Cornell Davison, M.D., Guest Speaker

Dr. Wilburt Cornell Davison, son of the Reverend William L. Davison, D.D., and Mattie Cornell Davison, was born in Grand Rapids, Mich., on April 28, 1892. After receiving the A.B. degree from Princeton in 1913, as a Rhodes Scholar he attended Oxford University in England, where he won the degrees of B.A. in 1915, B.Sc. in 1916 and M.A. in 1919. In 1917, he received the M.D. degree from the Johns Hopkins University School of Medicine. Honorary degrees conferred later were D.Sc. in 1932 by Wake Forest College and LL.D. in 1944 by the University of North Carolina.

From 1919 to 1927, Dr. Davison served as instructor, associate professor, acting head of the department of pediatrics and assistant dean at the Johns Hopkins University School of Medicine, and also as pediatrician, acting pediatrician in charge, and editor of The Bulletin of the Johns Hopkins Hospital. Since 1927 he has been dean and professor of pediatrics at Duke University School of Medicine.

In 1914 and 1915, Dr. Davison served in the American Red Cross in France and Serbia. As a first lieutenant and captain in the Army Medical Corps, he was with the American Expeditionary Force from 1917 to 1919.

Among the many important posts filled by this eminent pediatrician are consultant to the Office of Surgeon General, U. S. Army; honorary consultant to the Army Medical Library; director of the Doris Duke Foundation; former member and vice chairman of the division of medical sciences of the National Research Council, member of its committee on atomic casualties and chairman of its committee on veterans' medical problems; member of the medical advisory panel of the Oak Ridge Institute of Nuclear Studies, Council of Chief Consultants of the Veterans Administration, and Board of Governors of the Playtex Park Research Institute.

This distinguished member of numerous medical societies is a fellow of the American College of Physicians and the American Academy of Pediatrics and holds membership on the editorial board of the Quarterly Review of Pediatrics, Book of Health, and Child-Family Digest. He is the author of Pediatric Notes, 1925; Enzymes (with S. A. Waksman) 1926; The Compleat Pediatrician, now in its sixth edition since 1934, and many articles in medical and other scientific journals. In addition to Phi Beta Kappa, his fraternities are Sigma Xi, Omicron Delta Kappa and Alpha Omega Alpha.



MALCOLM B. DOCKERTY, M.D.
Mayo Clinic
Rochester, Minn.



CHESTER C. GUY, M.D.
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W. L. THOMAS, M.D.
Associate Professor of Obstetrics and Gynecology
Duke University School of Medicine
Durham, North Carolina

PROGRAM

of the

Eightieth Annual Meeting

FLORIDA MEDICAL ASSOCIATION

to be Held at HOLLYWOOD

APRIL 26, 27 and 28, 1954

REGISTRATION

East End of Exhibit Hall

The Registration Desk will be located at the East end of the Exhibit Hall and will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and Wednesday, 8:30 a.m. to 12:30 p.m. Every member will be required to register and obtain an identification badge before attending any of the sessions. Guests and ladies are required to register at the above designated Registration Desk and obtain their badges.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Pool Patio at 9:00 p.m. Monday and worn throughout the evening.

CONVENTION HEADQUARTERS

Hollywood Beach Hotel

The general headquarters will be the Hollywood Beach Hotel, where the registration desk, assembly room for general sessions, meeting place of the House of Delegates, scientific assemblies, information desk and technical and scientific exhibit halls will be located.

The Hollywood Beach Hotel will be headquarters Saturday and Sunday for the specialty groups approved by the Board of Governors.

GOLF

The annual handicap golf tournament for members of the Florida Medical Association will be played at the Hollywood Beach Hotel Links. The tournament will be held Sunday, Monday and Tuesday, April 25, 26 and 27. There will be no green fees for members registered at the Hollywood Beach Hotel. Those registered elsewhere will be charged $1.00 per day. Transportation and lockers furnished free of charge.

Those wishing to participate must be registered and show F.M.A. badges.

Rules: U. S. Golf Association, except local rules.

The entrant must register with the starter before beginning his tournament round. An entrance fee of $1.00 is to be paid to the starter. Score card must be dated, signed, attested and turned in to the starter at the end of the round. The local professional will handicap the players using the Calloway Handicap system.

There will be three awards. The Orlando cup is awarded annually to the low net scorer. Last year's winners were Drs. Robert C. Piper of Miami and Joseph W. Taylor Jr. of Tampa with a tie score. The Duval County Medical Society trophy is awarded to the low gross scorer. Last year's winner was Dr. Walter F. Davey of Stuart. The Keleket X-Ray award is limited to the radiology division of the tournament. Last year's winner was Dr. James T. Shelden of Lakeland.

In addition to the three trophies, numerous other prizes will be awarded in this year's tournament.

Those desiring further information are asked to communicate with Dr. A. Judson Graves, Secretary, F.M.A. Golf Committee, 2002 Park St., Jacksonville 4.

ANGLERS

Enjoy a deep sea fishing trip while at the Convention. Parties arranged for half day or all day trips. Prizes will be awarded for the various kinds, sizes and greatest number of fish caught.

For reservations and information please contact Dr. Curtis H. Sory, 1400 S. Andrews Ave., Fort Lauderdale.

SMOKER

Monday, 9:00 p.m.

Hollywood Beach Hotel — Pool Patio

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

Hollywood Beach Hotel — Main Dining Room

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

HOTELS

Hollywood Beach — Hotel Headquarters

(American Plan)

Single $18.00 Double $36.00

American Plan rates at the Hollywood Beach Hotel includes meals, which are priced as follows:

Breakfast	$1.75
Luncheon	3.50
Dinner	5.75

Persons not lodging at the headquarters hotel may be served meals in the Main Dining Room at the prices quoted. Individual meal tickets sold at cashier's window will include 10% to cover gratuities for those who do not have rooms in the Headquarters Hotel.

For your convenience we have arranged with the hotel management that there shall be no tipping at any meal. A charge of $1.25 per day will be posted to your hotel account to provide gratuities for dining room employees.

OTHER HOTEL ROOMS

Fowler's Great Southern

(Hollywood Blvd.)

Single Rooms	$ 3.50- 5.00
Double Rooms	$ 7.00- 8.00

Hutchinson

(404 N. 17th Ave.)

Double Rooms (first floor)	$ 4.00
Double Rooms (other)	$ 3.00

Royal Palm

(1957 Jackson St.)

Single Rooms	$ 3.00
Double Rooms	$ 4.00

SHELDON
(100 Boardwalk)

Single Rooms	$ 5.00
Double Rooms	$ 7.00

SURF
(300 Boardwalk)

Single Rooms	$ 7.00
Double Rooms	$11.00

MOTELS

BOUGAINVILLEA
(1040 S. Federal)

Single Rooms	$ 4.00- 5.00
Double Rooms	$ 5.00- 6.00
Apartments (per day)	$ 8.00-12.00

DILLOWS
(1831 Plunkett St.)

Single Rooms	$ 4.00
Double Rooms	$ 5.00
One bedroom apartments (weekly)	$35.00-40.00

FILSON
(1753 Jackson St.)

Single Rooms	$ 4.00
Double Rooms	$ 5.00

APARTMENTS

BEACH AND TOWN
(1010 S. Federal)

Double Rooms	$ 8.00- 8.50
Efficiency Apartments (daily)	$10.00

MERMAID
(319 Pierce St.)

Efficiency Apartments (daily)	$ 8.00- 9.00

TECHNICAL EXHIBITS

Technical exhibits will be located in the Great Lounge of the Hollywood Beach Hotel. The technical exhibits have a real scientific value, and the physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way. Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting.

The following firms have arranged for exhibits at the Hollywood meeting:

Booth	Exhibitor
1.	American Academy of General Practice, Florida Chapter
2.	The S. E. Massengill Company
3.	General Electric Company, X-Ray Dept.
4.	The Wm. S. Merrell Company
5.	Gerber Products Company
6.	G. D. Searle & Co.
7.	Eli Lilly and Company
8.- 9.	Keleket X-Ray of Florida
10.	C. B. Fleet Co. Inc.
11.-12.	The Coca-Cola Company
13.	Florida Brace Corporation
14.	Tablerock Laboratories, Inc.
15.	Warner-Chilcott Laboratories
16.	Chas. Pfizer & Company, Inc.
17.	Ciba Pharmaceutical Products, Inc.
18.	A. H. Robins Company, Inc.
19.	The National Drug Company
20.-21.	Surgical Equipment Company
22.	Parco Surgical Supplies
23.	E. R. Squibb & Sons
24.	Pet Milk Company
25.	Picker X-Ray Corporation
26.	Ortho Pharmaceutical Corporation
27.	Lederle Laboratories Division
28.	Sherman Laboratories
29.	Sandoz Pharmaceuticals
30.-31.	Amedic Surgical Company
32.	Central-Ethex, Inc.
33.	White Laboratories, Inc.
34.	Ayerst Laboratories
35.	Rowland Laboratories
36.	Winthrop-Stearns Inc.
37.	The Medical Protective Company
38.	Hoffmann-LaRoche Inc.
39.	Brown & Williamson Tobacco Corp.
40.-41.	General Foods Corporation
42.	J. B. Lippincott Company
43.	The Upjohn Company
44.	Anderson Surgical Supply Co.
45.	The Baker Laboratories, Inc.
46.-47.	Ritter Company, Inc.
48.	Carnation Company
49.	Miles Reproducer Company, Inc.
50.	A. S. Aloe Company
51.	Walker Laboratories, Inc.
52.	Hart Drug Corporation
53.	U. S. Radium Corporation
54.	McNeil Laboratories, Inc.
55.	Ives-Cameron Company, Inc.
56.	Burroughs Wellcome & Co. (U.S.A.) Inc.
57.	J. A. Majors Company
58.	Abbott Laboratories
59.	Bilhuber-Knoll Corp.
60.	The Borden Company
61.	Eisele & Company
62.	Ames Company, Inc.
63.	Mead Johnson & Company
64	Holland-Rantos Company, Inc.
65.	Blair's Associate
66.	Florida Oxygen Service
67.	P. Lorillard Company, Inc.
68.-69.	Schoetker-Thomas-Koch X-Ray Co.
70.	U. S. Vitamin Corp.
71.	Sharp & Dohme
72.	Schering Corporation
73.	Beech-Nut Packing Company
74.	Parke, Davis & Company
75.	VanPelt & Brown, Incorporated
76.	Wyeth Laboratories
77.	R. J. Lindquist Company
78-79.	Westinghouse Electric Corp., X-Ray Division
80.	Eaton Laboratories, Inc.
81.	Medical Supply Company
82.	Guild of Prescription Opticians of Florida
83.	Executone, Inc.
84.	R. J. Reynolds Tobacco Company
85.	J. B. Roerig and Company
86.	Audio-Digest Foundation

SCIENTIFIC EXHIBITS

The scientific exhibits will be located in the Arcade on the ground floor and in the lobby of the headquarters hotel. We consider ourselves fortunate to be able to present for your approval the following exhibits:

200. Urological Complications in Carcinoma of the Cervix Uteri, John O. Rao, M.D., Kissimmee.

201. The Medical Examiner System in a Medium-size Semi-Urban County, Alfred E. Cronkite, M.D., Fort Lauderdale, and John H. Mickley, M.D., Hollywood.

202. Interesting Pre and Post Operative Angiograms, Richard E. Strain, M.D., Irwin Perlmutter, M.D., and Jack W. Barrett, M.D., Miami.

203. How Can I Take Part in the Medical Meeting?, George F. Schmitt Jr., M.D., Miami.

204. Plastic Surgery of the Nose, John R. Lewis Jr., M.D., Atlanta, Ga.

205. Bureau of Professional Relations, College of Pharmacy, University of Florida, Mr. Charles S. Haupt, Associate Director.
206-207. Childhood Allergic Problems, W. Ambrose McGee, M.D., West Palm Beach.
208. Blue Shield of Florida, Inc., Leigh F. Robinson, M.D., President, Fort Lauderdale.
209-210. Skin Cancer of the Eyelid, Wesley W. Wilson, M.D., Tampa.
211-212. Fenestration Operation, J. Brown Farrior, M.D., Tampa.
213. The Transverse Incision in Female Pelvic Surgery, Robert W. Withers, M.D., and J. M. Ingram Jr., M.D., Tampa.
214-215. Uses of the Universal Flange Nail, Eugene L. Jewett, M.D., Orlando.
216. Public Relations, Florida Medical Association, Leigh F. Robinson, M.D., Fort Lauderdale.
217. Research in Cardiology, National Children's Cardiac Hospital, Milton S. Saslaw, M.D., Miami.
218. Woman's Auxiliary to the Florida Medical Association, Mrs. Julius C. Davis, Quincy.
219-220. Cancer Cytology in the Private Practice of Medicine: Every Physician's Office a Cancer Detection Center, The Cancer Institute at Miami, J. Ernest Ayre, M.D.
221. Trichominas Vaginalis Infections, Experimental and Clinical Study, Carl H. Davis, M.D., Miami.
223-224. Recent Advances in the Treatment of Lung Cancer, American Cancer Society, Florida Division, Hugh G. Reaves, M.D., President, Sarasota, and Mr. L. H. Peterson, Executive Vice President, Tampa.
225-226. Management of Poliomyelitis Patients with Respiratory Difficulty, The National Foundation for Infantile Paralysis, New York.
Lobby. Dade County Medical Association Activities for 1954, Edward W. Cullipher, M.D., President, Miami.
Lobby. A Medical Service Program for Your Community, American Medical Association, Mr. George B. Larson, Chicago.

CONVENTION COMMITTEES

Smoker

Ralph S. Sappenfield, *Co-Chairman*
Russell B. Carson, *Co-Chairman*
C. Jennings Derrick — Herbert E. White
James N. Patterson

Golf

Walter C. Jones, *Chairman*
A. Judson Graves, *Secretary*
Raymond L. Evans — David R. Murphey Jr.
David W. Martin

Anglers

Curtis H. Sory, *Chairman*
Thomas C. Kenaston — William H. Grace
V. Marklin Johnson — Eugene G. Peek Jr.

Greeters

Eugene B. Maxwell, *Chairman*
Graham W. King Jr. — Carl S. McLemore
Floyd K. Hurt — Alvin L. Mills

Woman's Auxiliary Advisory

C. Robert DeArmas, *Chairman*

Association Dinner

Samuel M. Day, *Chairman*
Frederick K. Herpel — Duncan T. McEwan

ALUMNI AND FRATERNITY SUPPERS

Monday, 7:00 p.m.

Hollywood Beach Hotel — Dining Rooms

EMORY

7:00 p.m. Supper and program — Sun Room

TULANE

6:30 p.m. Cocktails — Mardi Gras Lounge
7:00 p.m. Supper — Mardi Gras Lounge
8:00 p.m. Address, Conrad C. Collins, Professor and Head of the Gynecology Department, Tulane University of Louisiana, New Orleans — Mardi Gras Lounge

GEORGIA

7:00 p.m. Supper — Southeast Section, Main Dining Room

FORMER MAYO FELLOWS

7:00 p.m. Supper — Northwest Section, Main Dining Room

CINCINNATI

7:00 p.m. Supper — Southwest Section, Main Dining Room

DUKE

7:00 p.m. Supper — Northeast Dining Rooms
Address, Wilburt C. Davison, Dean, Duke University School of Medicine, Durham, N. C.

TEMPLE

7:00 p.m. Supper — Main Dining Room
Contact the Dining Room Head Waiter before 5:00 p.m. Monday for reservations in a section of the main dining room and give him the approximate number of plates to be served.

WINNERS OF THE ORLANDO LOVING CUP

The Orlando Loving Cup was donated by the Orange County Medical Society at the Annual Meeting of the Florida Medical Association in 1931 at Orlando.

1931—Mozart A. Lischkoff, Pensacola
1932—Clarence A. Rudisill, Tampa
1933—Blackburn W. Lowry, Tampa
1934—Heyward J. Blackmon, Tampa
1935—Mozart A. Lischkoff, Pensacola
1936—Shaler Richardson, Jacksonville
1937—J. R. Chandler, Daytona Beach
1938—William Y. Sayad, West Palm Beach
1939—James T. Cowart, Tampa
1940—Lucien B. Dickerson, Clearwater
1941—William C. Roberts, Panama City
1942—Clarence A. Rudisill, Tampa
1943—No tournament (war)
1944—No tournament (war)
1945—No tournament (war)
1946—Walter C. Jones, Miami
1947—Walter F. Davey, Stuart
1948—Robert D. Harris Jr., St. Augustine
1949—Dodge D. Mentzer, Lakeland
1950—William G. Meriwether, Plant City
1951—John D. McKey, Orlando
1952—Willard F. Ande, West Palm Beach
1953—Robert C. Piper, Miami, and Joseph W. Taylor Jr., Tampa

WINNERS OF THE DUVAL COUNTY SOCIETY TROPHY

The Duval County Society Trophy was donated by the Duval County Medical Society at the Annual Meeting of the Florida Medical Association in 1952 at Hollywood.

1952—John D. McKey, Orlando
1953—Walter F. Davey, Stuart

WINNER OF THE KELEKET X-RAY AWARD

1953—James T. Shelden, Lakeland

MONDAY

FIRST GENERAL SESSION

Monday, 9:30 to 9:45 a.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

Call to Order, Frederick K. Herpel, President

Invocation, The Reverend Harold C. Williamson, Rector, St. Johns Episcopal Church, Hollywood.

Address of Welcome, Edward W. Cullipher, Miami, President, Dade County Medical Association.

Introduction—Fraternal Delegates other states: J. W. Chambers, LaGrange, Ga.; R. M. Joiner, Moultrie, Ga.

Announcements

Adjournment

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Jere W. Annis, Chairman, Lakeland; Sidney Davidson, Lake Worth; Frederick K. Herpel, West Palm Beach; Richard C. Cumming, Ocala; Arthur J. Butt, Pensacola.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the secretary when read."

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

FIRST SCIENTIFIC ASSEMBLY

Monday, 9:45 a.m. to 12:30 p.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

9:45 a.m. "Extensive Surgery and Repeated Surgery for Malignant Diseases," Samuel M. Day, Jacksonville.
Discussion: Frederick J. Waas, Jacksonville
George T. Pack, New York City

10:15 a.m. "Recent Trends in Medical Education," George A. Bennett, Dean, Jefferson Medical College, Philadelphia.

10:45 a.m. "The Treatment of Inoperable Prostatic Carcinoma with Au 198," Louis M. Orr, James L. Campbell Jr. and Miles W. Thomley, Orlando.
Presented by Dr. Orr.

11:15 a.m. Recess to Visit Exhibits

11:30 a.m. "Rheumatic Fever in a Subtropical Climate," Milton S. Saslaw, Miami.
Discussion: Sidney Grau, St. Petersburg
William P. Hixon, Pensacola

12:00 a.m. "The Conquest of Pain," C. MacKenzie Brown, Tampa.

Visit the exhibits. They represent a tremendous financial investment.

SECOND SCIENTIFIC ASSEMBLY

Monday, 2:00 to 5:15 p. m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

2:00 p.m. "Cosmetic Surgery," George W. Robertson III, Miami.
Discussion: Bernard L. N. Morgan, Jacksonville

2:30 p.m. "Functioning Ovarian Tumors," Malcolm B. Dockerty, Mayo Clinic, Rochester, Minn.

3:00 p.m. "Pelvic Operations — the Preferred Vaginal Approach," W. L. Thomas, Department of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N. C.

3:30 p.m. Recess to Visit Exhibits

3:45 p.m. "Evaluation of Cardiovascular Surgery," DeWitt C. Daughtry and John G. Chesney, Miami.
Presented by Dr. Daughtry.
Discussion: Hawley H. Seiler, Tampa

4:15 p.m. "A Statistical Analysis of 181 Consecutive Cases of Bronchogenic Carcinoma," J. Brooks Brown, Jacksonville.
Discussion: Kenneth A. Morris, Jacksonville
DeWitt C. Daughtry, Miami

4:45 p.m. "Solitary Discrete Pulmonary Densities," George H. McSwain, Daytona Beach.
Discussion: Ashbel C. Williams, Jacksonville

ALUMNI AND FRATERNITY SUPPERS

Monday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL — DINING ROOMS

(see page 651)

SMOKER

Monday, 9:00 p.m.

HOLLYWOOD BEACH HOTEL — POOL PATIO



Pool Patio
Scene of Smoker on Monday Night

TUESDAY

FIRST MEETING HOUSE OF DELEGATES

Tuesday, 9:30 a.m.

Hollywood Beach Hotel — Mardi Gras Room

Delegates assemble at the Credentials Committee table at entrance of the Mardi Gras Room at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, Chairman
Herbert L. Bryans
Ralph W. Jack

Delegates are to occupy seats in the front section in order that they may be grouped together. Other members of the Association and guests are requested to occupy seats in the rear section of the room.

9:30 a.m., President Herpel in the Chair

Parliamentarian for the President — Joseph S. Stewart

Number of eligible delegates present. Report by Louis M. Orr, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Adoption of minutes as published in June 1953 Journal

Gavel to First Vice President, Thomas H. Bates

President's Address, Frederick K. Herpel.

President Resumes Chair

Election of two Delegates and two Alternates to A.M.A. House of Delegates for two year terms beginning January 1, 1955

(Terms expiring December 31, 1954 —
Delegate, Reuben B. Chrisman Jr.; Alternate, Frank D. Gray
Delegate, Herbert L. Bryans; Alternate, Thomas H. Bates)

Letter from Dr. George F. Lull, Secretary, A.M.A., dated Jan. 22, 1954:

(Your constituent association, therefore, is entitled to three (3) delegates in accordance with the apportionment now in effect of one delegate for each one thousand, or fraction thereof, active members.)

June 1952 Florida Medical Journal, page 857:

(The Chair ruled in order to elect a third Delegate to the A.M.A. House of Delegates for the remainder of 1952 and for a two year term beginning Jan. 1, 1953. Dr. Herbert L. Bryans was elected.)

(A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President

Presentation of Resolutions *(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)*

Reports of Committee Chairmen:

(To Reference Committee No. 1)

Scientific Work, Jere W. Annis
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton
Venereal Disease Control, Melvin M. Simmons
Tuberculosis and Public Health, Phillip W. Horn
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
Resolution: Joint consideration of fee schedule and income limits — Indian River County Medical Society

Resolution: Definition and regulation of use of word "Clinic" by all members of all branches of the healing arts — Dade County Medical Association

(To Reference Committee No. 2)

Conservation of Vision, Sherman B. Forbes
Legislation and Public Policy, H. Phillip Hampton
Medical Education and Hospitals, Jack Q. Cleveland
Medical Economics, Reuben B. Chrisman Jr.
State Controlled Medical Institutions, Samuel G. Hibbs
Representatives to Industrial Council, Frank L. Fort
Grievance, Walter C. Payne Sr.
Resolution: Discontinuation of Doctor Draft Law As of Its Expiration on June 1, 1955 — Sarasota County Medical Society

(To Reference Committee No. 3)

Board of Governors, Frederick K. Herpel
Public Relations, Leigh F. Robinson
Necrology, Alvin L. Stebbins
Advisory to Woman's Auxiliary, C. Robert DeArmas
Councilor Districts and Council, John D. Milton
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman
Resolution: Consideration of Some City Other Than Hollywood for the Annual Meeting — Sarasota County Medical Society.

New Business

Announcements

Adjournment

SECOND GENERAL SESSION

Tuesday, 11:30 a.m.

Hollywood Beach Hotel — Mardi Gras Room

Call to Order, Frederick K. Herpel, President

Address (By Invitation), "Changes in Medical Education and Patient Care," Wilburt C. Davison, Durham, N. C., Dean and Professor of Pediatrics, Duke University School of Medicine.

Adjournment

THIRD SCIENTIFIC ASSEMBLY

Tuesday, 2:30 to 5:15 p.m.

Hollywood Beach Hotel — Mardi Gras Room

Symposium, "The Differential Diagnosis of Jaundice"
Moderator, Eric E. Wollaeger, Mayo Clinic, Rochester, Minn.

2:30 p.m. "The Role of the Clinical History and Physical Examination," Eric E. Wollaeger, Rochester, Minn.

2:50 p.m. "The Role of Liver Function Tests and General Laboratory Findings," James L. Borland, Jacksonville.

3:10. p.m. "The Role of Liver Biopsy," Theodore C. Keller, Miami.

3:30 p.m. Questions and Panel Discussion

4:00 p.m. Recess to Visit Exhibits

4:15 p.m. "Vagotomy and Gastroenterostomy for Duodenal Ulcer," Chester C. Guy, Chief Surgeon, Illinois Central Railroad, Chicago.

4:45 p.m. "Management of Upper Gastrointestinal Hemorrhage," John M. Rumball, Coral Gables.
Discussion: Edwin J. Jensen, Miami
Thomas E. McKell, Tampa

REFERENCE COMMITTEES

Tuesday, 2:30 p.m.

HOLLYWOOD BEACH HOTEL

The three reference committees will meet on Tuesday at 2:30 p.m. in the Television Room, Southwest Porch and Men's Card Room. The names of the delegates who have been appointed by President Herpel to serve on reference committees are listed below:

1. HEALTH AND EDUCATION

TELEVISION ROOM

John D. Milton, Chairman
Jere W. Annis
G. Dekle Taylor
C. Frank Chunn
Francis T. Holland

2. PUBLIC POLICY

SOUTHWEST PORCH

Edward Jelks, Chairman
Donald W. Smith
V. Marklin Johnson
H. Phillip Hampton
William C. Roberts

3. FINANCE AND ADMINISTRATION

MEN'S CARD ROOM

Duncan T. McEwan, Chairman
Samuel M. Day
Warren W. Quillian
Francis H. Langley
Walter C. Payne Sr.

ASSOCIATION DINNER

Tuesday, 7:00 p.m.

HOLLYWOOD BEACH HOTEL — MAIN DINING ROOM

Speaker, Louis M. Orr, Orlando

Those who are not lodging at the headquarters hotel may obtain dinner tickets ($5.75 per person) from the hotel cashier.

VOUCHERS FOR PRIZES

At Association Dinner
Golf and Other Sports Events

WEDNESDAY

BOARD OF PAST PRESIDENTS

Wednesday, 8:00 a.m.

HOLLYWOOD BEACH HOTEL

MAIN DINING ROOM, NORTHEAST SECTION

Homer L. Pearson Jr., *Chairman*
Robert B. McIver, *Secretary*

Breakfast

Election of a Chairman and Secretary

(According to precedence, Herbert L. Bryans will succeed the present chairman and Frederick K. Herpel, the present secretary.)

FOURTH SCIENTIFIC ASSEMBLY

Wednesday, 9:00 to 10:00 a.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

9:00 a.m. "Epilepsy," William H. McCullagh, Jacksonville.
Discussion: James G. Lyerly, Jacksonville
Hugh A. Carithers, Jacksonville

9:30 a.m. "Muscular Dystrophy in South Florida," John E. Burch, Gaetano T. Samartino and William Pollen, Miami.
Presented by Dr. Burch
Discussion: Robert P. Keiser, Coral Gables
Irwin Perlmutter, Miami

Scientific and technical exhibitors have arranged elaborate informational displays. Attendants will be on hand at each booth to explain their exhibits and to answer your questions.

SECOND MEETING HOUSE OF DELEGATES

Wednesday, 10:30 a.m.

HOLLYWOOD BEACH HOTEL — MARDI GRAS ROOM

Delegates sign official attendance cards at 10:00 a.m. at the table of Credentials Committee, Louis M. Orr, Chairman, Herbert L. Bryans and Ralph W. Jack located at entrance to the Mardi Gras Room.

No Alternates are to be seated for Delegates attending yesterday's meeting.

President Herpel in the Chair, 10:30 a.m.
Number of eligible Delegates present. Report by Louis M. Orr, Chairman, Credentials Committee.
Recommendations of Reference Committees:
- No. 1. Health and Education
  John D. Milton, Chairman
- No. 2. Public Policy
  Edward Jelks, Chairman
- No. 3. Finance and Administration
  Duncan T. McEwan, Chairman

Other unfinished business
Election of Association Officers, 12:00 noon
- President-Elect
- First Vice President
- Second Vice President
- Third Vice President
- Secretary-Treasurer
- Editor of The Journal

Dr. Duncan T. McEwan escorted to the Chair as new President
Presentation of Personal Gavel to Dr. McEwan
Presentation of Past President's Button and Certificate of Honor to Dr. Frederick K. Herpel by Dr. Duncan T. McEwan, President
Adjournment

SPECIALTY GROUP MEETINGS

Saturday and Sunday, April 24-25

On July 25, 1948 the Board of Governors ruled that rooms be assigned to the various specialty group societies on Sunday, as heretofore, but that the State Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

SIXTH ANNUAL MEETING
FLORIDA **ALLERGY** SOCIETY

Officers

James H. Putman, President ..... Miami
Solomon D. Koltz, Vice Pres., Pres.-elect and Acting Secretary ..... Orlando
Lewis H. Palay,* Secy.-Treas. ..... Miami Beach
*Deceased

Sunday, April 25

Hollywood Beach Hotel — Stock Brokers' Room

8:45 p.m. 1. "The Early Recognition and Treatment of Allergy in Children," Milton B. Cole, St. Petersburg (by invitation).
Discussion: W. Ambrose McGee, West Palm Beach
Clarence Bernstein, Orlando

2. "Curbside" Consultations, Audience Participation — Queries invited on puzzling allergic problems from the "floor," James H. Putman, Miami, Moderator.

Panel: Frank C. Metzger, Tampa
Nelson Zivitz, Miami Beach
George F. Hieber, St. Petersburg
Solomon D. Klotz, Orlando

SIXTH ANNUAL MEETING
FLORIDA SOCIETY OF **ANESTHESIOLOGISTS**

Officers

Adelbert F. Schirmer, President ..... Orlando
R. Gaylord Lewis, President-elect ..... West Palm Beach
C. MacKenzie Brown, Vice President ..... Tampa
Breckenridge W. Wing, Secy.-Treas. ..... Orlando

Sunday, April 25

Hollywood Beach Hotel — "A" Dance Studio

9:00 a.m. Scientific Meeting
Business Meeting
Election of Officers

REGULAR MEETING OF THE FLORIDA ASSOCIATION OF
DERMATOLOGY AND **SYPHILOLOGY**

Officers

Morris Waisman, President ..... Tampa
Hollis F. Garrard, Vice President ..... Miami
Joseph A. J. Farrington, Secy.-Treas. ..... Jacksonville

Sunday, April 25

Time and place to be announced.

SIXTH ANNUAL MEETING
FLORIDA CHAPTER
AMERICAN COLLEGE OF **CHEST PHYSICIANS**

Officers

Nathaniel M. Levin, President ..... Miami
DeWitt C. Daughtry, Vice President ..... Miami
Hawley H. Seiler, Secy.-Treas. ..... Tampa
Jack Reiss, Program Chairman ..... Coral Gables

Sunday, April 25

Hollywood Beach Hotel — Flamingo Room

9:30 a.m. Business Session

10:00 a.m. Scientific Session

1. "Cancer of the Larnyx," Nathaniel M. Levin, Miami.
2. "Electrolyte Balance in Congestive Heart Failure," David A. Newman, Palm Beach.
3. "Funnel Chest Correction," DeWitt C. Daughtry and John G. Chesney, Miami.
4. "Recognition and Management of Child Allergy," Milton B. Cole, St. Petersburg.
5. "Extraperiostial Lucite Ball Plombage," Burnett Schaff, Jack Reiss and George C. Baum, Coral Gables.

Lunch — Guest Speaker, "A Discussion of Certain Preliminary Aspects of Pulmonary Mycotic Disease," Alvis E. Greer, President, American College of Chest Physicians; Clinical Professor of Medicine, Baylor University College of Medicine, Houston, Tex.

2:00 p.m. 6. Panel Discussion, "Chronic Cor Pulmonale," Morris Dick, George E. Baum, Jack Reiss, Coral Gables.
Moderator: M. Jay Flipse, Miami.

3:00 p.m. X-Ray Conference

All physicians of the Florida Medical Association and their guests are cordially invited to this meeting.

EIGHTH ANNUAL MEETING
FLORIDA ACADEMY OF **GENERAL PRACTICE**

Officers

Raymond R. Killinger, President ..... Jacksonville
Leonard L. Weil, President-elect ..... Miami Beach
Frank T. Linz, Vice President ..... Tampa
Leo M. Wachtel, Secy.-Treas. ..... Jacksonville

Sunday, April 25

Hollywood Beach Hotel — Mardi Gras Lounge

4:00 p.m. Business Session

8:00 p.m. Scientific Session: "Genito-Urinary Problems and the General Practitioner," J. Lester Wilke, Chicago.

NINTH ANNUAL MEETING
FLORIDA **HEALTH OFFICERS'** SOCIETY

OFFICERS

Lorenzo L. Parks, President ..... Jacksonville
Thomas E. Morgan, Vice Pres. ..... Jacksonville
Clarence L. Brumback, Secy.-Treas. West Palm Beach

Sunday, April 25

HOLLYWOOD BEACH HOTEL — SOUTHWEST PORCH

2:00 p.m. Scientific Session

1. "The Relationship of the Health Officers' Duties with Practicing Physicians," Wilson T. Sowder, Jacksonville.
   Discussion: V. Marklin Johnson, West Palm Beach
2. "County Health Units in Florida," George A. Dame, Jacksonville.
   Discussion: Warren T. Weathington, Apalachicola
3. "Recent Studies of Enteric Infections," Albert V. Hardy, Jacksonville.
4. "Tetanus in Florida," Charles J. Mathes, Miami.
   Discussion: Turner E. Cato, Miami.
5. "Health Center Financing and Functional Design," Paul W. Hughes, Fort Lauderdale.
   Discussion: Mr. Robert G. Carter, Jacksonville
6. "The Money Value of the Mid-Twentieth Century Florida Man," J. Basil Hall, Mount Dora.
7. "Infectious Hepatitis," James O. Bond, Punta Gorda.
   Discussion: William A. Walter, Jacksonville.
8. "Problems with Poliomyelitis in Florida." Lorenzo L. Parks, Jacksonville.
   General Discussion

FIFTEENTH ANNUAL MEETING
FLORIDA ASSOCIATION OF
INDUSTRIAL AND **RAILWAY SURGEONS**

OFFICERS

Lloyd J. Netto, President ..... West Palm Beach
Plumer J. Manson, President-elect ..... Miami
Henry L. Harrell, Vice President ..... Ocala
John H. Mitchell, Secy.-Treas. ..... Jacksonville

Sunday, April 25

HOLLYWOOD BEACH HOTEL — NORTHEAST DINING ROOMS

4:00 p.m. Scientific Session
"Use of Tandelon Mesh in Hernia Repair," Chester C. Guy, Chief Surgeon, Illinois Central Railroad, Chicago.

Business Session

Election of Officers

EIGHTH ANNUAL MEETING
FLORIDA SOCIETY OF
NEUROLOGY AND **PSYCHIATRY**

OFFICERS

William H. McCullagh, President ..... Jacksonville
Sullivan G. Bedell, Vice President ..... Jacksonville
Roger E. Phillips, Secy.-Treas. ..... Orlando

Sunday, April 25

HOLLYWOOD BEACH HOTEL — "A" DANCE STUDIO

2:00 p.m. Scientific Session

1. "Medical Attitudes Toward Electroshock Therapy," Lowell S. Selling, Orlando.
   Business Meeting and Election of Officers.

SEVENTH ANNUAL MEETING
FLORIDA **OBSTETRIC** AND **GYNECOLOGIC** SOCIETY

OFFICERS

Ferdinand Richards, President ..... Jacksonville
Harold G. Nix, President-elect ..... Tampa
J. Champneys Taylor, Secy.-Treas. ..... Jacksonville

Sunday, April 25

HOLLYWOOD BEACH HOTEL — SUN ROOM

2:00 p.m. Business Session — Election of Officers

2:30 p.m. (1) "Uterine Bleeding Due to Malignant Neoplasms."

(2) "Pelvic Operations — The Preferred Vaginal Approach."

(3) "Some Psychosomatic Problems and Technics in Gynecology — illustrated with slides." W. L. Thomas, Associate Professor of Obstetrics and Gynecology, Duke University School of Medicine, Durham, N. C.

FIFTEENTH ANNUAL MEETING
FLORIDA SOCIETY OF
OPHTHALMOLOGY AND **OTOLARYNGOLOGY**

OFFICERS

Mozart A. Lischkoff, President ..... Pensacola
G. Tayloe Gwathmey, President-elect ..... Orlando
Charles W. Boyd, 1st Vice Pres. ..... Jacksonville
Blackburn W. Lowry, 2nd Vice Pres. ..... Tampa
Carl S. McLemore, Secy.-Treas. ..... Orlando

Sunday, April 25

HOLLYWOOD BEACH HOTEL — THEATRE

10:00 a.m. Scientific Session

1. President's Address: Mozart A. Lischkoff, Pensacola.
2. "Operations of Choice in Cancers of the Larynx," J. Brown Farrior, Tampa.
   Discussion: Thomas M. Edwards, Tampa.
   Thomas M. Irwin, Jacksonville.
3. "Cyclodiathermy: Results in Various Types of Glaucoma," Sherman B. Forbes, Tampa.
   Discussion: W. Jerome Knauer Sr., Jacksonville.
   Nathan S. Rubin, Pensacola.
   Douglas D. Martin, (by invitation), Tampa.
4. Business Meeting.
5. Annual Report of Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director.

2:00 p.m. Scientific Session

1. "The Management of Intraocular Foreign Bodies," Harvey E. Thorpe, Pittsburgh, Pa.
2. "Esophageal Odds and Ends," Francis E. LeJeune, New Orleans, La.
3. Election of Officers.

5:30 p.m. Cocktail Party

Members, Wives and Guests — Flamingo Room

Doctor: Will you register at each booth and show your appreciation of the exhibitor's fine cooperation and costly outlay?

EIGHTH ANNUAL MEETING FLORIDA **ORTHOPEDIC** SOCIETY

Officers

Herschel G. Cole, President ..... Tampa
Charles R. Burbacher, Vice President ..... Coral Gables
Newton C. McCollough, Secy.-Treas. ..... Orlando

Sunday, April 25

Hollywood Beach Hotel — Stock Brokers' Room

2:30 p.m. Business Meeting

TWELFTH ANNUAL MEETING FLORIDA SOCIETY OF **PATHOLOGISTS**

Officers

Alfred E. Cronkite, President ..... Fort Lauderdale
Ira C. Evans, Vice President ..... St. Petersburg
Clarence W. Ketchum, Secy.-Treas. ..... Tallahassee

Sunday, April 25

Hollywood Beach Hotel — Television Room

9:30 a.m. General Business Session
Election of New Members
Election of Officers

1:30 p.m. General Session
Seminar, Ovarian Tumors, Malcolm B. Dockerty, Mayo Clinic, Rochester, Minn.

TWENTIETH MEETING FLORIDA **PEDIATRIC** SOCIETY

Officers

C. Jennings Derrick, President ..... West Palm Beach
Lewis T. Corum, President-elect ..... Tampa
Wesley S. Nock, Secy.-Treas. ..... Coral Gables

Sunday, April 25

Hollywood Beach Hotel — Men's Card Room

2:00 p.m. "A Pediatrician Looks at the Behavior Problems of Children," A. Ashley Weech, The Children's Hospital Research Foundation; Department of Pediatrics, College of Medicine, University of Cincinnati.
Questions and Answers.
Business Meeting.

7:00 p.m. Dinner — Mardi Gras Room

8:00 p.m. "Paving the Way for Accepting the Inevitable," Dr. Weech.

SEVENTH ANNUAL MEETING FLORIDA **PROCTOLOGIC** SOCIETY

Officers

John J. Cheleden, President ..... Daytona Beach
Edward C. Watt, Vice President ..... Jacksonville
George Williams Jr., Secy.-Treas. ..... Miami

Sunday, April 25

Hollywood Beach Hotel — "B" Dance Studio

10:15 a.m. "The Anatomy of the Liver as Related to Proctology," George A. Bennett, Dean and Professor of Anatomy, The Jefferson Medical College, Philadelphia, Pa.

2:00 p.m. Business Meeting — Fellows Only

4:00 p.m. Scientific Meeting

7:00 p.m. Round Table Discussion

TWENTY-THIRD ANNUAL SPRING MEETING FLORIDA **RADIOLOGICAL** SOCIETY

Officers

Nelson T. Pearson, President ..... Miami
A. Judson Graves, Vice President ..... Jacksonville
Hugh G. Reaves, Secy.-Treas ..... Sarasota

Saturday, April 24

Hollywood Beach Hotel — Theatre

2:00 p.m. Round Table Discussion — Diagnosis
7:00 p.m. Dinner — Main Dining Room

Sunday, April 25

Hollywood Beach Hotel — Mardi Gras Lounge

9:30 a.m. Business Session and Election of Officers

ANNUAL MEETING FLORIDA CHAPTER AMERICAN COLLEGE OF **SURGEONS**

Officers

Frederick J. Waas, President ..... Jacksonville
Joseph S. Stewart, Vice Pres. ..... Miami
David R. Murphey Jr., Secy.-Treas. ..... Tampa

Sunday, April 25

Hollywood Beach Hotel — Mardi Gras Room

10:00 a.m. Presentation of the Charter, H. Prather Saunders, Associate Director of the American College of Surgeons.

"Surgical Treatment of Hepatic Tumors," George T. Pack, Memorial Hospital, New York.

SEVENTH ANNUAL MEETING FLORIDA **UROLOGICAL** SOCIETY

Officers

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Linus W. Hewit, President-elect ..... Tampa
David W. Goddard, Secy.-Treas ..... Daytona Beach

Sunday, April 25

Hollywood Beach Hotel — Mardi Gras Room

2:00 p.m.
1. "Two Cases of Proliferative Cystitis," Angel Golderos, Havana, Cuba.
2. "Radical Removal of the Prostate for Carcinoma by the Retropubic Approach," Roberto Pedroso, Havana, Cuba.
3. "Pyelographic Clinic"
4. Business Meeting
5. Election of Officers
6. Cocktail Party

ANNUAL MEETING FLORIDA **CANCER** COUNCIL

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George W. Morse ..... Pensacola
Paul J. Coughlin ..... Tallahassee
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Chas. J. Collins ..... Orlando

Sunday, April 25

Hollywood Beach Hotel — Parlor 546

8:00 p.m. Business Meeting

NINTH ANNUAL MEETING
BLUE SHIELD OF FLORIDA

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Samuel M. Day, Asst. Treasurer ..... Jacksonville

Sunday, April 25

HOLLYWOOD BEACH HOTEL — THEATRE

8:00 p.m. Dr. Robinson presiding

MEETING
FLORIDA MEDICAL
COMMITTEE FOR **BETTER GOVERNMENT**

OFFICERS

Samuel G. Hibbs, Chairman ..... Tampa
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Collin F. Baker Jr., Secretary ..... Tampa
Charles F. Henley, Treasurer ..... Jacksonville

Sunday, April 25

HOLLYWOOD BEACH HOTEL — SUN ROOM

10:00 a.m. Business Meeting

THE TECHNICAL EXHIBIT

One feature that always adds materially to the success of an annual meeting is the technical exhibit. Every firm represented in the display features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m. On Wednesday it will be open 8:30 a.m. to closing time, 12:30 p.m., following which booths may be dismantled.

AMERICAN ACADEMY OF GENERAL PRACTICE, FLORIDA CHAPTER — 1

THE S. E. MASSENGILL COMPANY — 2

GENERAL ELECTRIC COMPANY, X-RAY DEPT. — 3

THE WM. S. MERRELL COMPANY — 4

TACE, the unique non-steroid developed by Merrell, *offers a new approach to the treatment of the menopause.*

TACE is temporarily stored in body fat, and released over an extended period of time. One course of TACE therapy is generally all that is required to ease many patients into the symptom free postmenopausal period. Symptom relief is excellent, and side effects are virtually absent.

Merrell professional service representatives will be present to answer any questions you may have concerning this new and distinctive estrogen. They will be happy to discuss other Merrell specialties as well.

GERBER PRODUCTS COMPANY — 5

G. D. SEARLE & CO. — 6

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine, and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

ELI LILLY AND COMPANY — 7

You are cordially invited to visit the Lilly exhibit. The display will contain information on recent therapeutic developments and will feature the story of the Lilly Junior Taste Panel. Lilly sales people will be in attendance. They welcome your questions about 'Ilotycin' (Erythromycin, Lilly) and other Lilly products.

KELEKET X-RAY OF FLORIDA — 8-9

We are, as always, looking forward with a great deal of pleasure to the Florida Medical Association Convention to see so many of our good friends that we have earnestly served during the more than 25 years of operation in the state of Florida.

All members of the Florida Medical Association are cordially invited to visit with us in our Booth.

C. B. FLEET CO. INC — 10

During the past fifty years, PHOSPHO-SODA (FLEET) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT — an enema solution of Phospho-Soda (Fleet) — is a worthy companion product. The single use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema, it is a boon to the hospitalized patient.

THE COCA-COLA COMPANY — 11-12

FLORIDA BRACE CORPORATION — 13

Florida Brace Corporation, Winter Park, will exhibit THE JEWETT BRACE, for hyperextension of the spine (Journal of the International College of Surgeons, Volume 12, #4, April 1950) for the treatment of spinal conditions requiring positive hyperextension, such as simple compression fractures, Osteoporosis, Adolescent Epiphysitis, and Marie Struempell's Disease.

TABLEROCK LABORATORIES, INC. — 14

All members of the Florida Medical Association are cordially invited to visit our Booth where Tablerock Representatives will welcome you. TABOREA, our non-barbiturate sedative and BISMUTH VIOLET Vaginal Suppositories will be featured.

WARNER-CHILCOTT LABORATORIES — 15

Two important cardiovascular agents will be featured at the Warner-Chilcott booth: Methium — to lower blood pressure and relieve hypertensive symptoms and Peritrate — to prevent attacks in angina pectoris. Representatives and research personnel will welcome an opportunity to discuss these drugs with you.

CHAS. PFIZER & COMPANY, INC. — 16

CIBA PHARMACEUTICAL PRODUCTS, INC. — 17

The Ciba exhibit will feature SERPASIL, a pure crystalline alkaloid of Rauwolfia which usually produces mild, gradual sustained lowering of blood pressure with a slowing of the pulse rate.

Representatives in charge of the Ciba booth will be pleased to discuss the role of SERPASIL in the treatment of hypertension and to furnish literature on this new drug.

A. H. ROBINS COMPANY, INC. — 18

The A. H. Robins Company exhibit features ROBALATE, N.N.R., antacid-demulcent indicated in peptic ulcer therapy and hyperacidity. The pharmaceutically elegant tablets, each containing 0.5 Gm. dihydroxy aluminum aminoacetate, are notable for exceptional palatability.

THE NATIONAL DRUG COMPANY — 19

SURGICAL EQUIPMENT COMPANY — 20-21

The Surgical Equipment Company, Miami, cordially invites you to visit our exhibit where we will display the latest in surgical instruments and medical equipment.

PARCO SURGICAL SUPPLIES — 22

You are cordially invited to visit Parco's Booth. We will have on display some of the newer items of interest. Competent representatives will be happy to discuss or furnish information you may desire.

E. R. SQUIBB & SONS — 23

PET MILK COMPANY — 24

Specially trained representatives will be in attendance to discuss the use of Pet Evaporated Milk in infant feeding and Pet Nonfat Dry Milk for high protein diets. A variety of services that are time-savers for busy physicians will be furnished on request. Miniature Pet Milk cans will be given to visitors at the exhibit.

PICKER X-RAY CORPORATION — 25

Picker X-Ray will exhibit the first Operating Room Mobile Unit approved by the Underwriter Laboratories as safe for use in explosive atmospheres — mainly operating rooms.

In addition to this new unit, the Picker-Polaroid 1-Minute processing system will also be on display.

Technical consultants will be on booth duty and you are invited to discuss your x-ray problems with them.

ORTHO PHARMACEUTICAL CORPORATION — 26

LEDERLE LABORATORIES DIVISION — 27

SHERMAN LABORATORIES — 28

PROTAMIDE

A sterile colloidal solution of denatured proteolytic enzyme. Published clinical studies have convincingly established Protamide's value in neuritis, herpes zoster and tabes dorsalis.

NOVADONNA

An antispasmodic combining the levorotatory alkaloids of belladonna with homatropine methylbromide for greater spasmolysis and less side-effects.

(Continued on page 681)



Hollywood Beach Hotel — Convention Headquarters

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John R. Boling, M.D., 1944, 1945.....*Tampa*
Shaler Richardson, M.D., 1946.....*Jacksonville*
William C. Thomas Sr., M.D., 1947.....*Gainesville*
Joseph S. Stewart, M.D., 1948.....*Miami*
Walter C. Payne Sr., M.D., 1949.....*Pensacola*
Herbert E. White, M.D., 1950.....*St. Augustine*
David R. Murphey Jr., M.D., 1951.....*Tampa*
Robert B. McIver, M.D., Secy., 1952.....*Jacksonville*

The Journal of the Florida Medical Association

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Eightieth Annual Meeting

The spacious Hollywood Beach Hotel will again completely house the activities of the Florida Medical Association during its eightieth annual meeting, April 26-28. The beautiful Mardi Gras Room will be the scene of the two General Sessions, four Scientific Assemblies and the two meetings of the House of Delegates. The hotel will provide transportation to its golf course for the members participating in the handicap tournament. The complete program is published in preceding pages of this number of The Journal.

This year will see eighteen specialty groups convening during the weekend preceding the opening of the Association's meeting. All groups will hold one or more sessions on Sunday. One specialty society is scheduled for Saturday as well. The Ninth Annual Meeting of the Blue Shield of Florida has been scheduled for Sunday at 8:00 p.m. For the first time this year the Florida Medical Committee for Better Government will also meet in Hollywood. This meeting is scheduled for 10:00 a.m. on Sunday. Each group has been assigned a meeting room of such size as will be adequate for the attendance anticipated. The program for each of these groups appears in this issue.

Dr. Jere W. Annis, chairman of the Association's Committee on Scientific Work, together with the members of his committee, Drs. Sidney Davidson, Frederick K. Herpel, Richard C. Cumming and Arthur J. Butt, has prepared the program for the scientific assemblies. Four scientific assemblies have been scheduled, one each on Monday forenoon and afternoon and on Tuesday afternoon and Wednesday morning.

Dr. Frederick K. Herpel will deliver his presidential address at the first meeting of the House of Delegates on Tuesday morning. Following the meeting of the first House of Delegates on Tuesday, the guest speaker, Dr. Wilburt C. Davison of Durham, N. C., will read his paper at the second general session.

Drs. Ralph S. Sappenfield and Russell B. Carson, co-chairmen of the Smoker Committee, and the members of the committee, Drs. C. Jennings Derrick, Herbert E. White and James N. Patterson, have completed arrangements for the annual Smoker on Monday night, April 26. Another event of the same evening at 7:00 p.m. will be the Alumni and Fraternity Suppers in the hotel dining rooms.

The annual dinner of the Association is sched-

uled for Tuesday night at the hotel. In addition to participating in these social events featured annually, the members and their guests will have opportunity for diversified entertainment and recreation which will include golf, ocean and pool bathing, fishing, and sea or shore excursions.

In the Arcade on the ground floor there is a coffee shop called the "Rendezvous," which will serve meals at popular prices.

The Great Lounge of the hotel overlooking the ocean has been given over to the technical exhibits. Scientific exhibits will be displayed in the Arcade on the ground floor and in the lobby. They will present a wealth of information of value to specialists and general practitioners alike. The numerous technical exhibits will invite careful inspection. Attendants will be on hand at each booth to answer questions on the latest developments in equipment, drugs and other products displayed by the exhibiting firms.

Notice to Delegates and Committee Chairmen

The House of Delegates will hold its first 1954 meeting on Tuesday, April 27, at 9:30 a.m. in the Mardi Gras Room of the Hollywood Beach Hotel. The delegates are requested to assemble at the Credentials Committee table at 9:00 a.m. to present their credentials, fill out attendance cards and receive special badges. This table will be located at the entrance to the Mardi Gras Room. Delegates are to occupy seats in the front section in order that they may be grouped together. Other members of the Association and guest doctors are requested to occupy seats in the rear section of the room.

Chairmen of standing committees are urgently requested to be present on time so that their reports may be presented as scheduled in the official program, which is published in this issue of The Journal. Resolutions not included in the House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.

The second meeting of the House of Delegates will be held Wednesday, April 28, at 10:30 a.m. Delegates are required to fill out attendance cards for this meeting at 10:00 a.m. at the entrance to the Mardi Gras Room. These cards are the delegates' official attendance records. The By-Laws prohibit an alternate from serving for any delegate who was seated at the first meeting of the House.

At 12:00 noon on Wednesday, at this second meeting of the House, the election of officers of the Association for the ensuing year will take place.

Cultivating Serendipity

Once upon a time there were three princes of Serendip, who, "as their Highnesses traveled, were always making discoveries, by accidents and sagacity, of things they were not in quest of." This fascinating tidbit from the old fairy tale had such appeal for Horace Walpole, British author and wit of two centuries ago, that he coined the word serendipity. Having long since fallen into undeserved disuse, this word is now being rescued by scientists from the dusty oblivion of unabridged dictionaries to lend its poetic cadence to scientific journals.

Serendipity is an art — the art of finding things one is not looking for, of making unexpected discoveries. Webster defines it as "the gift of finding valuable or agreeable things not sought for," but "the art of profiting from unexpected occurrences" is the more telling definition of Dr. Irving Langmuir, famed scientist of the General Electric Research Laboratory. In most instances, scientific discoveries are the fruit of painstaking research, with each great success prefaced perhaps by a thousand failures, but some discoveries may drop right out of the blue, the gifts of happy chance. A wind blowing through a laboratory window, a key tossed carelessly upon a photographic plate — these are two of medicine's classic examples of serendipity. With the wind came the seeds of penicillin; the key unlocked the secrets of the X ray.

The wind blowing in Sir Alexander Fleming's window was not the first harbinger of penicillin. Scientists had already observed that some bacteria destroy others. It was Fleming, however, who perceived that something in the wind had contaminated the plate cultures of staphylococci on his laboratory bench. His scientific curiosity aroused, he looked closely, and there fringing the outer edge was the pale blue mold that had killed the staphylococci.

No less an artist in serendipity was Wilhelm Roentgen. After carelessly tossing a key on an undeveloped photographic plate covered with black paper, he turned on a cathode tube with

which he was experimenting. When by mistake the plate was developed and there appeared on the negative the outline of the key, he realized that the rays of the cathode tube had miraculously penetrated the black paper. Bitterly opposed and branded a charlatan by those who refused to believe that invisible rays could pass through an opaque substance, he nevertheless persisted until he eventually built the first x-ray machine.

In the weird laboratory of the alchemist research was more accident than art. Scientists today have come to expect the unexpected. They find in serendipity a practical art, and their faith in it is well founded. Their experience in the modern laboratory and scientific history both attest it. Chance and curiosity have surely played their role in the discovery of fire, for example; and all the basic crafts doubtless had their origin through "the magic nexus of happy chance and an alert imagination, which is the essence of the art of serendipity."

"Discovery can not be planned," said Dr. Langmuir recently. "But you can plan work that will lead to discoveries." He deliberately cultivates serendipity by never setting himself a specific goal. He just "has fun in the laboratory," for he finds that too many of the happenings there are unexpected and that many of them turn out to be the most profitable and the most useful. But his is organized fun with a purpose. In this atomic age science becomes infinitely more intricate and purposeful. Accumulated knowledge and refined technics at the command of scientists endowed with training and skill and imagination make them better prepared today than ever before to capitalize on the unexpected.

Alert as the scientist is, however, to the significant chance discoveries, these blue diamonds are not found solely in the laboratory. The rewards of cultivating the art of serendipity should be abundant for the clinician as well, for the specialist in every branch of medicine, in fact. The physician who practices good medicine has much to gain professionally by developing a talent for this peculiar art. Too, he may find his personal life greatly enriched by the blessings of happy chance if he will give free rein to serendipity. Here is a working philosophy which has living significance for scientist and physician alike, and likewise for Americans in every walk of life.

Our Editor Speaks

During the 1953 annual session of the Medical Association of Georgia, Dr. Shaler Richardson addressed the editorial board of its journal. Editor of the Journal of the Florida Medical Association for more than a quarter of a century, Dr. Richardson graciously shared with our friendly neighboring association on the North the fruits of his long term experience acquired during a period of unparallelled medical progress.

Titled "The Successful State Medical Journal," Dr. Richardson's address was received enthusiastically and upon publication in the Journal of the Medical Association of Georgia, promptly won national recognition. The State Journal Advertising Bureau of the American Medical Association brought it to the attention of state medical journal officials throughout the country by distributing reprints at the recent annual Editors and Managing Editors Conference in Chicago.

Dr. Richardson stressed thoughts which should be of paramount interest to the members of all state medical associations:

> To say that the journal of a state medical association is as good as its editors is also to say that it is only as good as the material the members provide for . . . [the editors'] utilization. No matter how well it is staffed and managed, no matter how attractive its format, its success obviously depends primarily on the subject matter provided by the members. . . .
>
> The Journal . . . is the outlet for the writings of the members of the association. The only papers by outsiders which we accept for publication are those read before Florida medical meetings. It . . . is therefore your journal, not merely from the standpoint of ownership but also from the standpoint of contributions. . . .
>
> **Scientific Articles**
>
> The quality of its scientific articles is a gauge of professional progress which, above all, determines the rating of any journal as a medical periodical. . . . The well prepared paper is always acceptable if it is opportunely timed and presents a practical subject. . . .
>
> **Abstracts**
>
> A particularly worth while feature . . . is an abstract department. Members of a state society whose articles are published outside the state deserve recognition in their own journal. . . .
>
> **Editorials and Commentaries**
>
> Reader interest may be enhanced by a strong editorial section — not partisan and controversial, but forthright and stimulating, dealing with subjects of vital interest to the medical profession. . . .
>
> **News Items**
>
> News items make up a popular section . . . which should contain only items of medical interest . . . pertaining to . . . postgraduate studies,

visits to clinics and hospitals, addresses on medical subjects, military service assignments, and office or committee assignments. . . .

Other Features

Sections devoted to the Blue Shield, State Board of Health, Books Received, Correspondence and the Woman's Auxiliary all have their place in a state journal. . . .

In discussing finances, Dr. Richardson pointed the way to economy and explained the handling of advertising, a vital source of revenue. Naturally, the better the journal, the more appeal it has to advertisers. This phase, as all others in the publication of a successful medical journal, leads right back to the grass roots of individual members. their interest and their participation.

The Journal congratulates its Editor on his able presentation, which set forth his observations and conclusions accumulated during many years of devoted service. Members of the Florida Medical Association will do well to keep in mind that our Journal can be only as good as we make it.

Webster Merritt

Presenting a Scientific Paper

The sufferings of one physician-listener at important meetings over a period of 30 years led him to offer helpful suggestions to future speakers. Dr. Richard A. Kern, secretary-general of the American College of Physicians, in a timely article,[1] has recorded his observations and advice for the benefit of his colleagues who engage in public speaking. A reprint of this article has been sent to the members of the Association who are essayists on the scientific program for the Eightieth Annual Meeting next month, and one may be obtained by other members, on request, at Association headquarters.

At the outset, Dr. Kern points out that the fixed time limit assigned is the outside time limit, which begins with the first word of introduction by the chairman and ends when the speaker finishes or is requested to stop. The worst sin against the time limit, and the best way to ruin prospects for future invitations, is in his opinion an attempt to read a 23 minute paper in 20 minutes. Instead, a 17 minute paper is best suited for successful presentation in that length of time.

Involved in correct use of the microphone is recognition of its strict limitations. Since it magnifies by a fixed number that which the speaker puts into it, he must maintain a fixed distance between it and his mouth. An aid in doing so is to hold with one hand to the edge of the lectern from start to finish. If one would alternately shout and whisper to his audience, he has only to rock back and forth on his feet as he speaks, or alternate between standing up straight and leaning confidentially on the lectern. The best distance between the mouth and a fixed lectern microphone is 7 to 10 inches.

There are limitations of voice as well as of microphone. Chief among them are direction, loudness and pitch. Dr. Kern likens the microphone to a person with catarrhal deafness: it hears the speaker well only while he keeps the pitch of his voice up, and the loudness adequate. Equally important, if he speaks too loudly, his voice blares and becomes painfully unintelligible. He must remember, too, to keep his hands away from his mouth and also to keep his manuscript from blanketing the microphone.

The article has numerous valuable tips on lantern slide technic. Even more important than the "Do's" are the "Don't's," but both invite careful study.

Practice at home with any good recording device, tape or wire, will permit any prospective lecturer to be his own severest critic, recognize his deficiencies and correct them in private. Once he recovers from hearing the voice of an utter stranger come back to him out of the machine, he can begin to assess his most obvious mistakes of presentation, the hurried delivery, probably, or the monotonous intonation and all the irrelevant "ah's" and "uh's."

"Now," Dr. Kern continued, "if your ego can still take it, have a motion-picture as well as a sound-track recording made of one of your presentations. See for yourself your distracting, and therefore undesirable habit of scratching your face, rubbing your nose, twisting your ear or tugging on a lock of hair. Do you ever look at the people you are trying to impress, or are your eyes glued to your manuscript? And what of your gestures? Gestures, like spices, add zest and interest, if unobtrusive, appropriate to the matter in hand, and if used sparingly; but better no gestures than too many or the wrong ones, awkwardly made."

The presentation of a scientific paper may be an infrequent and ephemeral activity for the many, as Dr. Kern observed. Nevertheless, for the essayist who accepts a place on a scientific

program there is an obligation — to self, to the listeners and to those who afforded him the opportunity — to have something worth saying and to say it as well as possible.

1. Kern, R. A.: How to Present a Scientific Paper Before a Large Audience, Ann. Int. Med. 37:618-624 (Sept.) 1952.

Health Excerpts from President's State of the Union Message

At this writing late in January, President Eisenhower's State of the Union message and other later messages to the Congress this month are very much in the news. The following excerpts from the State of the Union message cover medical and health issues which are of particular interest to the medical profession:

SOCIALIZATION OF MEDICINE: "I am flatly opposed to the socialization of medicine. The great need . . . can best be met by the initiative of private plans. But it is unfortunately a fact that medical costs are rising and already impose severe hardships on many families. The federal government can do many things and still avoid the socialization of medicine."

RESEARCH: "The federal government should encourage medical research in its battle with such diseases as cancer and heart ailments, and should continue to help states in health and rehabilitation."

HILL-BURTON PROGRAM: "The present . . . act should be broadened to assist in the development of adequate facilities for the chronically ill . . . of diagnostic centers, rehabilitation facilities and nursing homes."

REINSURANCE OF HEALTH PLANS: "The war on disease . . . needs a better working relationship between government and private initiative. . . . A limited government reinsurance service would permit the private and non-private insurance companies to offer broader protection to more of the many families which want and should have it."

REHABILITATION: "The program for rehabilitation of the disabled especially needs strengthening. . . . This program presently returns each year some 60,000 handicapped individuals to productive work. Far more disabled people can be saved each year . . . if this program is gradually increased."

MILITARY DEPENDENTS: "Pay alone will not retain in the career service . . . the necessary number of long-term personnel. I strongly urge, therefore, a more generous use of other benefits important to service morale. Among these are more adequate living quarters, and medical care for dependents."

MEDICAL TAX DEDUCTIONS: ". . . we propose more liberal tax treatment for dependent children who work, for widows or widowers with dependent children, and for medical expenses."

VETERANS: "The internal reorganization of the Veterans Administration is proceeding with my full approval. When completed, it will afford a single agency whose services, including medical facilities, will be better adapted to the needs of those 20 million veterans to whom the Nation owes so much.

SOCIAL SECURITY: "I ask that this extension (to 10,000,000 more persons) soon be accomplished. This and other major improvements . . . will bring substantial benefit increases and broaden the membership of the insurance system, thus diminishing the need for Federal grants-in-aid. . . ."

A.M.A. Statement on Proposed Eisenhower Health Plan

On January 24 the Board of Trustees of the American Medical Association met to discuss the implications of the proposed Eisenhower health plan, especially that portion which urged establishment of a $25 million federal corporation to "reinsure" voluntary health insurance plans. After discussing the President's proposals with representatives of both the nonprofit and the commercial insurance companies and then engaging in full debate, the Board issued the following statement:

"The Board of Trustees of the American Medical Association has given careful study to the President's Message on Health delivered to Congress on January 18. The Board is pleased to find in this message so many of the ideas and principles for which the American Medical Association has striven for so many years.

"The Board endorses the general objectives of the President to extend needed facilities, to promote further research, to increase coverage under voluntary health insurance and to rehabilitate the disabled.

"These are certain basic principles which the American Medical Association feels are essential in the consideration of any voluntary health insurance program: there must be free choice of

physicians and hospitals; the program must be founded on sound actuarial data and there must be no direct or indirect control of the program by the government.

"The Administration's federal reinsurance proposal is indefinite. It is not clear whether this is true reinsurance or another form of government subsidy. This whole subject needs careful study and until the plan is spelled out in detail the American Medical Association can make no further comment.

"The American Medical Association feels that there may be other approaches to the problem of the extension of health coverage than that of federal reinsurance. For example, the A.M.A. has strongly supported legislation to permit deduction from income for tax purposes of medical and hospital bills and premiums paid for voluntary health insurance."

President Eisenhower's Special Message on Health

In a special message to the Congress in mid-January on the nation's health problems, President Eisenhower made these proposals:

Medical Care — Reinsurance. "Better health insurance protection for more people can be provided. . . . The government can and should work with them (private and non-profit organizations) to study and devise better insurance protection to meet the public need. . . . I recommend the establishment of a limited federal reinsurance service to encourage broader health protection to more families. This service would reinsure the special additional risks involved in such broader protection. It can be launched with a capital fund of $25 million provided by the government, to be retired from reinsurance fees."

Rehabilitation. "There are 2,000,000 disabled persons who could be rehabilitated and thus returned to productive work. Only 60,000 now are being returned each year. Our goal should be 70,000 in 1955. . . . For 1956, 100,000. . . . In 1956 the states should begin to contribute to the cost of rehabilitating these additional persons. . . . By 1959, with . . . states . . . sharing with the federal government, we should reach the goal of 200,000. . . . We must extend greater assistance to the states (for) . . . specialized training of personnel . . . research, clinical facilities for rehabilitative services . . . the development of community centers and special workshops."

Construction of Medical Facilities. "New hospital construction continues to lag behind the need . . . (but) . . . hospital construction meets only part of the urgent need for facilities . . . I . . . propose added assistance or assistance in the construction of (a) non-profit hospitals for care of chronically ill, (b) non-profit medically supervised nursing and convalescent homes, (c) non-profit rehabilitation facilities for the disabled, (d) non-profit diagnostic or treatment centers for ambulatory patients. . . . I (also) recommend . . . special funds be made available to the states to help pay for surveys of their needs."

Other Federal Programs. A "new approach" in grant-in-aid would apply a "simplified formula . . . permitting the states to use greater initiative in state programs and take more responsibility. . . . States (would be) aided in inverse proportion to their financial capacity. . . . A proportion of the federal assistance to be set aside for support of unique projects of regional or national significance which give promise of new and better ways of serving the human needs of our citizens."

Report of Delegates to A.M.A. St. Louis, Dec. 1-4, 1953

The American Medical Association held its Seventh Annual Clinical Session in St. Louis, December 1 to 4, 1953. The House of Delegates met at the Jefferson Hotel, where it heard addresses by A.M.A. President, Dr. Edward J. McCormick of Toledo, Ohio, by the Speaker of the House, Dr. James R. Reuling of Bayside, N. Y., and by several guests including Dr. Chester Keefer, special assistant to Secretary Oveta Culp Hobby of the Department of Health, Education and Welfare. Dr. Joseph I. Greenwell of New Haven, Ky., was honored by being named the 1953 "General Practitioner of the Year." Annual reports were presented by Dr. George F. Lull, Secretary and General Manager of the A.M.A., Dr. Dwight H. Murray of Napa, Calif., Chairman of the Board of Trustees, and by standing and special committees of the House.

The House reaffirmed its opposition to compulsory coverage of physicians under the Old Age and Survivors Insurance provisions under Title II of the Social Security Act and recommended passage of the Jenkins-Keogh bills now pending in Congress. These bills provide for "the development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians."

The reference committee on legislation and public relations urged continued action to obtain passage of the Bricker Amendment (S. J. Res. 1) and approved the principle of legislation which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. It opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955. In part the report read: "Your Committee feels strongly . . . that there should be no further extension of the 'Doctor Draft' law. It feels that the legislation is discriminatory and urges the Committee on Legislation and the Board of Trustees to oppose actively any further extension. . . ."

The House of Delegates acted to accelerate the development of voluntary health insurance by passing a resolution requesting the Council on Medical Service to proceed at once with a special study of the problems of catastrophic coverage and coverage for retired persons. The council was asked to present its findings and recommendations to the House not later than the 1954 Clinical Meeting. The resolution pointed out:

"There are two large groups of citizens for whom improved coverage could be offered under present prepaid medical care plans, namely: (a) those individuals who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the cost thereof and (b) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans."

A resolution adjudged to be emergency business by the Reference Committee on Insurance and Medical Service and later passed by the House stated that "the American Medical Association condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous actions of the House defining pathology, radiology, anesthesiology and physiatry as medical services.

A second emergency resolution, which would have endorsed the principle of federally subsidized scholarships for prospective military personnel in order to encourage the building up of a career-basis medical corps for the armed forces, was referred by the House to the Board of Trustees for study and action.

The Iowa State Medical Association introduced a resolution calling for approval of a joint billing procedure involving services rendered by two or more physicians. This was referred to the Judicial Council at the suggestion of the Reference Committee on Miscellaneous Business with the recommendation that the Judicial Council "investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

A revision of one section of the Principles of Medical Ethics of the A.M.A. which clarifies the relationship of physicians to all forms of public information mediums was approved by the House. The revision had been recommended by the Council on Constitution and Bylaws.

The House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study the publicity problems resulting from unethical practices by a small minority of doctors. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June 1954 meeting in San Francisco.

In order to clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of General Practice in hospitals, the House adopted the following resolution:

"That this House of Delegates of the American Medical Association request the Joint Commission on Accreditation of Hospitals to publish an article, or series of articles, in The Journal of the American Medical Association and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, bylaws, and their interpretations; and . . .

"That the commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

This Journal contains the complete program for the Eightieth Annual Meeting at Hollywood — April 25-28.

For the fourth time a grant of $500,000 was made by the A.M.A. to the American Medical Education Foundation as an aid to the nation's medical schools. The Foundation reported that its 1953 income now totals $1,174,000 and that the number of contributions is now more than double the total in 1952.

Dr. Louis H. Bauer, of New York, immediate past president of the A.M.A., was elected president of the Foundation just prior to the opening of the A.M.A. Clinical Session. He succeeds the late Dr. Elmer L. Henderson of Louisville, Ky., also an A.M.A. past president.

Just prior to the Clinical Meeting, the A.M.A. Council on Foods and Nutrition presented Dr. James S. McLester of Birmingham, Ala., a practicing physician for more than 50 years, the Joseph Goldberger award for outstanding contributions in the field of clinical nutrition.

The St. Louis meeting attracted 2,730 physicians with a total registration of approximately 8,000. The technical and scientific exhibits were the largest in the seven year history of the Interim Sessions. Color television was one of the highlights at the meeting along with motion pictures which had been carefully selected for their general interest by the Committee on Medical Motion Pictures. An interesting phase of the program was a three dimensional film which was shown daily.

The St. Louis Municipal Auditorium is one of the larger auditoriums in the country, and ample room was provided for scientific meetings as well as for the needed space for exhibits. It was spacious and permitted dignity which is not often attainable at a meeting of this size.

The special exhibit on fractures was popular as were the manikin demonstrations on problems of delivery. These exhibits were presented several times daily and resulted in unusually large audiences. An added feature was a consultation service where physicians could discuss their problems with a group of medical and surgical experts. The question and answer conference on diabetes was filled to capacity at all times. Clinical lectures included surgery, obstetrics, gynecology, internal medicine and therapeutics, arthritis and rheumatism, cardiovascular diseases, pediatrics, pulmonary diseases, gastrointestinal disease, neurology and psychiatry, and many other miscellaneous subjects.

Only eight Florida physicians registered at this meeting.

The next meetings scheduled for the A.M.A. will be held as follows:

1954 Annual Meeting, June 21-25, San Francisco.
1954 Clinical Meeting, November 30-December 3, Miami.
1955 Annual Meeting, June 6-10, Atlantic City.
1955 Clinical Meeting, November 29-December 2, Boston.
1956 Annual Meeting, June 11-15, Chicago.

Respectfully submitted,
Reuben B. Chrisman Jr., M.D.
Louis M. Orr, M.D.

Graduate Medical Education

Plans are going ahead for the Twenty-Second Annual Graduate Short Course for doctors of medicine to be given July 12-16, 1954 at the George Washington Hotel in Jacksonville. The lectures on Medicine will be given by Dr. George T. Harrell, newly appointed Dean of the College of Medicine of the University of Florida. This occasion will afford the physicians of Florida an excellent opportunity to meet Dr. Harrell.

The Committee on Medical Postgraduate Course is also glad to announce that Dr. H. Barton McSwain of Vanderbilt University will deliver the lectures on Surgery. Dr. McSwain is known to many physicians of Florida as an excellent teacher and he is particularly well fitted to give these lectures.

The Short Course this year is limited to five days. The attendance heretofore on Saturday morning has hardly justified holding the faculty over for the number of lectures given. The Committee will be pleased to have the reaction of the members of the Association to this change.

A course in Hematology will be offered on July 8-10, just prior to the Short Course, at the George Washington Hotel in Jacksonville. The subject of Hematology was selected because of the many requests of the physicians over the state. Certified technicians will be admitted to this course. Other technicians will be admitted only if sponsored by a physician.

A Seminar on Medicine and Surgery was presented by the faculty of the Department of Medicine of the Graduate School of the University of Florida at the Florida Union Auditorium in Gainesville on Jan. 27, 1954. This Seminar was

co-sponsored by the Alachua County Medical Society and the Marion County Medical Society. The physicians of the Putnam County Medical Society also were invited to attend.

Forty-four physicians were in attendance from Gainesville, Ocala, Palatka, Starke, Hawthorne, Eustis, Dunnellon and McIntosh.

During the afternoon session a diagnostic clinic was held by Dr. Edward Jelks and Dr. Karl B. Hanson of Jacksonville. Lectures on "Surgical Aspects of Chest Conditions" by Dr. Kenneth A. Morris of Jacksonville and on "Metabolic Disease" by Dr. Fred Mathers of Orlando were presented. At a buffet dinner at the Gainesville Country Club the guest speakers were Dr. Russell Poor, Provost of the Health Center, and Dr. George T. Harrell, Dean of the College of Medicine of the University of Florida. Dr. Walter C. Jones of Miami lectured on "Tumors of the Stomach" and Dr. James L. Borland of Jacksonville on "Jaundice" at the evening session.

The Seminar was presented through the cooperation of the Florida Medical Association and the Florida State Board of Health. It represents the type of graduate medical education which the faculty of the Department of Medicine can offer any medical society in the state upon request.

Eighth Midwinter Seminar in Ophthalmology and Otolaryngology

For the eighth successive year, the University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology was held in Miami Beach, January 18-23. The Sans Souci Hotel was again headquarters. The 1954 meeting was one of the most enthusiastic yet held, with a record attendance of 225. There were registrants from 37 states and two foreign countries. This wide distribution attests the nationwide interest in this major feature of the Florida Postgraduate Medical Education program sponsored annually by the Department of Medicine of the Graduate School of the University of Florida. Of special interest this year were six commercial exhibits.

The usual midweek social features were an informal gathering at the cocktail hour on Wednesday afternoon in the Blue Sails Room of the Sans Souci and a dinner that night at the Saxony Hotel, with more than 300 in attendance.

The members of the distinguished faculty who lectured on Ophthalmology the first three days were Dr. W. Banks Anderson, Durham, N. C.; Dr. William P. Beetham, Boston; Dr. William C. Owens, Baltimore; Dr. Algernon B. Reese, New York City; and Dr. Maynard C. Wheeler, New York City. Those presenting the lectures on Otolaryngology the last three days were Dr. Edwin N. Broyles, Baltimore; Dr. Howard P. House, Los Angeles; Dr. W. J. McNally, Montreal, Canada; Dr. Dorothy Wolff, New York City; and Dr. DeGraaf Woodman, New York City.

Midwinter Convention of Florida Society of Ophthalmology and Otolaryngology

With President Mozart A. Lischkoff presiding, the seventh midwinter convention of the Florida Society of Ophthalmology and Otolaryngology was held on Wednesday afternoon, Jan. 20, 1954 at the Sans Souci Hotel in Miami Beach. As in previous years, this meeting took place in conjunction with the Midwinter Seminar in Ophthalmology and Otolaryngology sponsored by the Department of Medicine of the Graduate School of the University of Florida.

Dr. Howard P. House of Los Angeles and Dr. William C. Owens of Baltimore were the guest speakers on the scientific program. Dr. House spoke on "Congenital and Acquired Ear Canal Atresia" and "Surgical Management of Meniere's Syndrome," presenting motion pictures. "Ocular Foreign Bodies" was the subject of Dr. Owens' address.

Following the meeting, the members and their wives and the many visiting physicians and their wives were entertained at the cocktail hour and later attended the dinner which is the usual midweek social feature of these annual occasions.

On Sunday, January 17, immediately preceding the opening of the Seminar, the annual meeting of the Society's medical advisory committee to the Florida Council for the Blind was held. Those in attendance were Drs. William Y. Sayad, chairman, West Palm Beach; Sherman B. Forbes, Tampa; Charles C. Grace, St. Augustine; Bascom H. Palmer, Miami; Nathan S. Rubin, Pensacola, and Shaler Richardson, Jacksonville. Several representatives of the Council were present.

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. John S. Cowdery of Jacksonville announce the birth of a son. James Taylor, on Dec. 22, 1953.

Dr. and Mrs. Richard C. Clay of Miami announce the birth of a daughter, Madelyn, on Dec. 29, 1953.

Dr. and Mrs. Lee E. Bransford Jr. of Jacksonville announce the birth of a daughter, Mary Ann. on Jan. 13, 1954.

Dr. and Mrs. Samuel M. Day of Jacksonville announce the birth of a son, William Dekle, on Feb. 23, 1954.

Marriages

Dr. Milton C. Maloney and Mrs. Katherine Dutton Boardman, both of Jacksonville, were married on Jan. 7, 1954.

Dr. John M. Schultz of Miami and Miss Twilla Turner of Jacksonville were married on Dec. 6, 1953. in New York.

Dr. Eugene D. Simmons of Jacksonville and Mrs. Kathryn Rafford Suggs of Miami were married recently.

Deaths — Members

Cooper, John H., Commerce, Ga.	Nov. 14, 1953
Johnson, Whedon, Sarasota	Dec. 19, 1953
Swift, Walker E., Sarasota	Dec. 20, 1953
Alford, Neil, Jacksonville	Jan. 17, 1954
Dalton, Raymond J., Key West	Jan. 18, 1954
Mansfield, Max R., Coral Gables	Jan. 20, 1954
Maguire, Thomas C., Plant City	Jan. 29, 1954
Gridley, Roger W., Orlando	Jan. 31, 1954
Wilson, John F. Jr., Lakeland	Jan. 31, 1954
Walsh, Gerald J., Miami Shores	Feb. 7, 1954
Hanson, Henry, Jacksonville	Feb. 13, 1954

Deaths — Other Doctors

Davila, Jose A., Bayamon, Puerto Rico	1941
Merrill, Joseph H. Jr., South Miami	Dec. 17, 1953
Parker, Julius A. (Col.), Gainesville	Jan. 7, 1954
Vance, John R., Orlando	Jan. 31, 1954

Medical Officers Returned

Dr. Frank C. Bone, who entered military service on Nov. 17, 1952, was released from active duty on Aug. 28, 1953 with the rank of lieutenant, U.S.N.R. His address is American Bldg., Orlando.

Dr. John A. Ray, who entered military service on March 10, 1951, was released from active duty on Dec. 21, 1953 with the rank of captain, U. S. Army. His address is 213 Church St., Mulberry.

Dr. James A. Winslow Jr., who entered military service on Oct. 30, 1952, was released from active duty on Jan. 31, 1954 with the rank of lieutenant, U.S.N.R. His address is Citizens Building, Tampa.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Armbruster, James W., Coral Gables
Bacon, Alfons R., Bradenton
Barry, Carey N., Fort Myers
Brown, Harry W., St. Petersburg
Brown, Warren J., Largo
Carver, James C., Fort Myers
Cato, Robert E., Daytona Beach
Coggins, Wilmer J., Boca Grande
Darby, Lee H., New Smyrna Beach
DeLaney, Allen Y., Gainesville
Eckel, Edward J., Everglades
Eisenbarth, Elmer J., Marathon
Friedl, Lois E., Orlando
Gaines, Gartrell J. Jr. (Col.), W. Palm Bch.
Guerin, B. Bowman, Vero Beach
Hamilton, Edward L., Gainesville
Harrow, Benedict R., Miami
Herbert, Carl M. Jr., Gainesville
Hodge, James B. Jr., Tampa
Hoffman, Milton J., Orlando
Jones, Gus W. Jr., West Palm Beach
Landham, Jackson W. Jr., Orlando
Lee, John P., Clearwater
Litt, Edward T., Miami Beach
McMillan, Jesse C., Miami Shores
Northup, Aldrich H., Pensacola
Palmer, Margaret, Ocala
Patras, Mary C., Miami
Perry, Richard E., Gainesville
Robertson, James G., Miami
Silberman, Harold M., Coral Gables
Smedley, John T., Miami
Smith, W. Landon, DeLand
Smoak, Henry E. Jr., Clearwater
Stepner, A. Lester, Miami
Ward, Jack P., Orlando
Watkins, Maltby F., Fort Pierce
Williams, Gerald S., Daytona Beach
Young, L. Roland, Daytona Beach
Zarzecki, Casimer A., Miami

STATE NEWS ITEMS

Dr. George Thomas Harrell Jr. has been appointed dean of the College of Medicine of the University of Florida. Dr. Harrell joins the University staff from the Bowman Gray School of Medicine of Wake Forest College where he was director of the Department of Internal Medicine and Research Professor of Medicine.

At the January meeting of the Greater Miami Radiological Society, the following officers were elected: Drs. E. Hampton Bryson, Coral Gables, president; Raymond E. Parks, Miami, vice president; and Richard D. Shapiro, Miami Beach, secretary-treasurer.

Dr. Walker Stamps of Jacksonville has been named a director of the Harvard Club of Jacksonville for the ensuing year.

Dr. G. Dekle Taylor of Jacksonville has been elected a board member of the Michigan Club of Jacksonville for the coming year.

Drs. Joseph C. Wilson and Henry C. White Jr. of Fort Walton spoke on unsanitary conditions which may be menacing the health of residents of the city at a January meeting of the Fort Walton Beach Rotary Club.

Dr. Estella G. Norman of Miami Springs gave a lecture and demonstration before the John Harvey Kellogg Health Club on January 20.

Drs. J. Sudler Hood and Percy H. Guinand of Clearwater gave brief talks on "Latest Aspects on Heart Diseases," at a weekly luncheon meeting of the Rotary Club of Clearwater on January 20.

Dr. Eugene L. Jewett of Orlando was guest speaker at the weekly luncheon meeting of the Kiwanis Club of that city on January 15. He spoke on the progress made to date in the field of polio research.

Drs. Richard E. Strain and Irwin Perlmutter of Miami announce the association of Dr. Jack W. Barrett for the practice of neurological surgery.

Dr. Robert T. Spicer of Miami, dean of the University of Miami School of Medicine, was guest of honor at a luncheon meeting of the Cornell Club of Southeastern Florida in January.

Dr. Alfred S. Massam of Bartow is the new president of the Bartow Exchange Club.

Dr. Leon S. Eisenman announces the opening of his offices at 760 East Fourth Ave., Hialeah.

Dr. Donald W. Smith of Miami spoke on the importance of early diagnosis of lung cancer at a meeting of the Dade County Bar Association in December.

Dr. Frank G. Slaughter of Jacksonville spoke at the regular luncheon meeting of the Lakeland Rotary Club in December.

Dr. Bennett J. LaCour Jr. of Daytona Beach has been elected to the Chamber of Commerce Board of Governors of that city.

Dr. Isaac M. Hay of Melbourne was a recent guest speaker at a meeting of the Brevard Hospital Guild in Melbourne.

Dr. Douglas R. Murphy of Venice, now on duty with the Navy at Key West, addressed the Venice-Nokomis Rotary Club in January on the habits and customs of the Japanese.

On the recommendation of Dr. C. MacKenzie Brown of Tampa, a "Pain Clinic" was formally established with the Tampa Municipal Hospital on Jan. 19, 1954. Nerve blocks for diagnosis and therapy have been performed there for several years previous to this time.

Dr. Frederick D. Droege of Sarasota spoke to nurses on a hearing program at the Public Health Section of District No. 19, Bradenton, and District No. 20, Sarasota, in January.

Dr. Paul S. Jarrett of Miami spoke on "The Psychosomatic Approach to Compensation Cases" before the Florida Industrial Commission's Annual Educational Conference, Nov. 12, 1953, at the Empress Hotel, Miami Beach. Dr. Jarrett was the first speaker of the University of Miami's Mental Health Lecture Series, on February 11. His subject was "A Psychiatrist Looks at Problems of Physical Health."

The Heart Association of Palm Beach County had as its guest on January 7 and 8, Dr. Robert P. Glover of Philadelphia.

Dr. Leland H. Dame of Orlando, director of the Orange County Health Department and Orange County Health Officer, has retired after 20 years of public service. He was appointed to the Florida State Board of Health in 1933 and later served as a district health officer for seven years.

Dr. Leon N. Greene of Miami took part in a program on "A Report of the Kinsey Report," at a meeting of the Surfside-Golden Beach Junior Chamber of Commerce on January 14.

Dr. Robert E. Rothermel of St. Petersburg spoke on "Gamma Globulin in Today's Health" at a meeting of the North Ward Parent-Teacher Association on January 12.

Dr. Reuben B. Chrisman Jr. of Miami was a featured speaker at the Seventh Annual Public Relations Conference of the North Carolina Medical Association in Raleigh, N. C., February 12.

President Frederick K. Herpel of West Palm Beach was a guest of the Upholsterers' Internation Union of North America at an Inauguration Dinner in Palm Beach on February 10.

A meeting of the Committee on Medical Education and Hospitals was held in Jacksonville, Sunday, February 14, with Dr. Jack Q. Cleveland, Miami, chairman, presiding. Also in attendance were Drs. S. Carnes Harvard, Brooksville, and Joseph W. Douglas, Pensacola.

The Florida Medical Association was well represented at the Regional Conference on Legislation held on January 31 in Atlanta. Present were Drs. Reuben B. Chrisman Jr., Miami; A. Judson Graves, Jacksonville; John E. Maines Jr., Gainesville; Cecil M. Peek, West Palm Beach; George H. Garmany and Francis T. Holland, Tallahassee; and H. Phillip Hampton, Tampa. Mrs. Richard F. Stover of Miami, president-elect of the Woman's Auxiliary, represented that group. In attendance from the headquarters office were Ernest Gibson and Harold Parham.

Representatives from Alabama, Florida, Georgia, North Carolina, South Carolina, Missouri, Mississippi, Tennessee and Kentucky met to discuss the legislation of interest to the medical profession which is pending before Congress or which may be introduced.

Dr. Chrisman, a member of the A.M.A. Committee on Legislation, was co-chairman of the Conference with Dr. W. Clark Bailey of Harlan, Ky.

Dr. Roderic L. Boling of St. Petersburg received the Silver Beaver Award, highest recognition a local council can bestow on a volunteer Boy Scout worker. The presentation was made during a special award program on January 14. Dr. Boling has been camp doctor for eight consecutive seasons.

Dr. Irving L. Alberts of Miami Beach has been appointed to Draft Board 169, Miami Beach.

Drs. George W. Karelas of Newberry and Andrew J. Barry of Starke took a week of postgrduate work at the Tulane University of Louisiana Medical School and Charity Hospital at New Orleans, January 10-17. The course which is held annually is given to bring general practitioners up to date in medical and surgical advances. The chairman of the course is Dr. Alton Ochsner.

Dr. Julian A. Rickles of Miami led the discussion following the showing of the American Cancer Society film, "The Traitor Within," at a meeting of the Women's Group of the Flagler Granada Jewish Community Center on January 21.

Dr. Freeman D. Stanford of Orlando was a guest speaker at the meeting of the College Park Woman's Club in January. His subject was the March of Dimes.

The Medical Association of the Isthmian Canal Zone announces the forthcoming Pan-American Medical Convention to be held at the El Panama Hotel, Panama City, March 24-26, 1954, according to Dr. Irving J. Strumpf, president. The Convention will celebrate the fiftieth anniversary of Panamanian independence and the fiftieth anniversary of the advent of American medicine in the Canal Zone in the person of Gen. William C. Gorgas in 1904.

The Convention will be conducted in both Spanish and English. United States citizens require only proof of their citizenship. Reservations may be made through the El Panama or International Hotels or by contacting the Tivoli Travel Agency, Box 979, Ancon, Canal Zone.

Dr. Jack Q. Cleveland of Coral Gables is state centennial committee chairman for the special two-day celebration to be held at the Emory University School of Medicine next October 4 and 5. The centennial year of the School will be recognized in a special program which will feature a series of lectures by nationally prominent physicians. The program will also include a formal academic ceremony, preceded by an academic procession of university and medical school officials, and representatives of medical schools and societies attending the celebration.

Dr. Joseph S. Stewart of Miami, chairman of the Third Annual Seminar and Conference on Cancer Cytology to be conducted by the Cancer Institute at Miami, announces that the Conference will be held on April 21-24.

The Conference will bring together several leading authorities on cancer from this country and abroad. The last day will be devoted to a special session for general practitioners, who will visit the Cancer Institute to see demonstrations on the taking and preparation of cytodiagnostic tests for cancer of many types, with special sessions devoted to cancer of the uterus, breast, prostate, lung and stomach. The latest advances in cancer diagnosis using new cytological methods and blood testing procedures will be presented.

Members of Dr. Stewart's Committee include: Dr. Virgil H. Moon, honorary chairman; Drs. Richard M. Fleming, Ralph W. Jack and Milton M. Coplan of Miami. The program will be conducted under the direction of Dr. J. Ernest Ayre.

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YOUNG DOCTOR: Finishing residency Ob-Gyn at Grady Hospital, Atlanta, Ga., July 1954, is interested in association with an Obstetrician-Gynecologist. Has Florida license and is a family man. Write 69-110, P. O. Box 1018, Jacksonville, Fla.

PATHOLOGIST: Excellent training. Desires position beginning July. Young, married. Completing formal Pathology Board training in June. Write 69-111, P. O. Box 1018, Jacksonville, Fla.

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GENERAL SURGEON: Age 38; Board certified, training just completed; category IV; family; Florida license; University training; desires association or partnership leading to a permanent position. Write 69-112, P. O. Box 1018, Jacksonville, Fla.

Drs. Jere W. Annis of Lakeland and George T. Harrell Jr. of Gainesville, dean of the University of Florida Medical School, were among the authors contributing to the preparation of "The Book of Health," a new "medical encyclopedia for everyone." The book was compiled and edited by Randolph Lee Clark Jr., M.D., and Russell W. Cumley, Ph.D.

Dr. Frederick D. Droege of Sarasota will be one of the speakers at the annual meeting of the American College of Allergy in Miami Beach, April 5 through 10. His subject will be "All Is Not Asthma That Wheezes — Broncholith."

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AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications[1]	Side Effects Requiring Discontinuance of Drug[2]	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6[3]			2			13
Bechgaard, Nielsen, Bang, Gruetund, Tobiassen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34[4]				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6[5]			18			
Maier, Merh	38	38	24			14[6]	27	7	4[7]				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McOonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49[8]	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42[9]									42
Shairken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4[10]	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.
2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."
3. Four had no symptoms when Banthine therapy was begun.
4. Of which seven were penetrative lesions and five partially obstructive.
5. No symptoms were present in four.
6. Two with symptoms only; no demonstrable ulcer.
7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.
8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.
9. All returned to work within a week
10. In these four, alter relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.

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COMPONENT SOCIETY NOTES

Alachua

The Alachua and Marion County Medical Societies recently co-sponsored a seminar on medicine and surgery at the University of Florida in Gainesville. It was presented by the Department of Medicine of the Graduate School of the University.

Dade

At the regular meeting of the Dade County Medical Association on February 2, Dr. Francis N. Cooke spoke on "Blood Vessel Transplants — Present Status." The paper was discussed by Drs. Richard C. Clay and Donald W. Smith.

Duval

Dr. Russell S. Poor, Provost of the Health Center, and Dr. George T. Harrell, Dean of the College of Medicine, University of Florida, addressed the Duval County Medical Society on February 2 on the present status of the plans for the College of Medicine at the University.

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Hillsborough

At the regular meeting of the Hillsborough County Medical Association on February 2, Dr. Donald W. Smith of Miami spoke on "The Rationale of Continuous Feeding in the Critically Ill."

Representatives of the Hillsborough County Medical Association attended a round-table discussion of insurance problems at a meeting of the Florida West Coast Accident & Health Association in January. Representing the Association were Drs. H. Phillip Hampton, Joseph A. Pendino, Richard C. Rodgers and William R. Crosby of Tampa.

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1954.

Lake

The Lake County Medical Society held its regular meeting on February 3. Dr. Walter A. Derrick of Orlando spoke on rare diseases and showed slides.

Lee-Charlotte-Collier-Hendry

Dr. Frederick K. Herpel of West Palm Beach, president of the Association, will be the guest speaker at the March 15 meeting of the Lee-Charlotte-Collier-Hendry County Medical Society in Fort Myers.

Marion

The Marion County Medical Society joined with the Alachua County Medical Society to spon-

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sor a seminar on medicine and surgery in Gainesville in January.

Dr. Allen Y. DeLaney of Gainesville spoke on "Medical Pearls from the Ochsner Clinic" at the regular meeting of the Society on February 16.

Pinellas

Dr. F. A. D. Alexander, chief of anesthesiology, Veterans Administration Hospital, Dallas, Tex., and professor at the Southwestern Medical College, University of Texas, spoke on "Management of Pain in Terminal Cancer," at a joint meeting of the Pinellas County Medical Society and the staff of the Veterans Administration Center, Bay Pines, on January 14, at the Lakewood Country Club.

Putnam

The Putnam County Medical Society has paid 100 per cent of its state dues for 1954.

Seminole

Dr. Walter A. Derrick of Orlando was guest speaker at the meeting of the Seminole County Medical Society on January 12 in Sanford.

The Seminole County Medical Society has paid 100 per cent of its state dues for 1954.

Volusia

President Frederick K. Herpel of West Palm Beach will speak at the regular monthly meeting of the Volusia County Medical Society on March 9.



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A Mental Health Plan

The importance of creating a permanent place in our routine community living for the development of Mental Health, as well as its maintenance, is being emphasized through magazine articles, books, television and radio.

People everywhere are now receptive to the discussion of Mental Health. What formerly had been a topic confined to departments of psychiatry and psychology is now being discussed in homes, schools and clubs.

This is significant. It reveals that we are reachable, and that the educational efforts expended in this field have created interest and have stimulated thought which is a prerequisite to any form of action.

The action desirable in this instance is the formation of Mental Health Societies in every community. There is a natural reluctance on the part of any one person to spearhead such a vast movement, due, in part, to the fact that persons who are inclined to take the initiative in such activities are usually booked to the hilt with other projects. Established clubs, dedicated to other purposes, are reluctant to assume leadership because of the time-consuming ramifications of this subject.

The formation of a Mental Health Society can be accomplished, however, if each civic club already in existence offers a carefully appointed Mental Health Chairman to represent it. This would create a nucleus Mental Health Group of city wide participation.

The Medical Auxiliary could be of value by urging its interested members to form a coordinating planning forum. This is a logical threshold group because information is available to them; they are identified with medical education, and because such activity asists the doctor in his service to the public.

Mrs. C. Robert DeArmas

Twenty-Seventh Annual Meeting
Woman's Auxiliary to
The Florida Medical Association
Hollywood, April 25-28, 1954



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TWENTY-SEVENTH ANNUAL MEETING

WOMAN'S AUXILIARY

TO THE

FLORIDA MEDICAL ASSOCIATION

Convention Committee

Mrs. A. Fred Turner Jr., Orlando, *Chairman*
Mrs. Roger E. Phillips, Orlando
Mrs. William S. Mitchell, Orlando

REGISTRATION

East End of the Exhibit Hall

Sunday, Monday, and Tuesday, 8:30 a.m. to 5:30 p.m.
Wednesday, 8:30 a.m. to 12:30 p.m.

A most cordial invitation is extended to the members of the Woman's Auxiliary to the Florida Medical Association, and to the wives and guests of physicians attending the convention of the Florida Medical Association to be present at the general sessions of the Woman's Auxiliary and to participate in all of its social events.

There is no fee for registration. Printed programs may be obtained at the Registration Desk.

Pay for Smoker privileges at the Registration Desk and obtain your receipt tag which is to be shown at the Pool Patio at 9:00 p.m. Monday and worn throughout the evening.

Please register promptly and obtain your badge, program and tickets.

Members of the Hospitality Committee will be at the hotel to assist you in any way they can. It is our sincere hope that your visit will be most profitable and very pleasant.

PROGRAM

Sunday, April 25

3:00 p.m. Pre-Convention Board Meeting, Hollywood Beach Hotel, Parlor 455. Members of the Board are state officers, state chairmen, and county Auxiliary presidents. Members-at-large and county presidents-elect are especially invited to attend.

Monday, April 26

Hollywood Beach Hotel — Flamingo Room

9:00 a.m. General Auxiliary Session
- Call to Order, Mrs. Thomas C. Kenaston, President
- Invocation, The Reverend Harold C. Williamson, Rector, St. John's Episcopal Church, Hollywood
- Pledge of Loyalty, Mrs. William C. Williams Jr., Delray Beach
- A Message from the Association, Dr. Frederick K. Herpel, West Palm Beach, President, Florida Medical Association
- Remarks from our Advisory Board, Dr. C. Robert DeArmas, Daytona Beach
- Greetings to the Auxiliary, Mrs. William S. Mitchell, Orlando
- Response, Mrs. Lee Rogers Jr., Cocoa
- Introductions, Mrs. Thomas C. Kenaston
- Presentation of Convention Chairmen, Mrs. A. Fred Turner Jr., Orlando
- Announcements
- Roll Call, Mrs. Nelson A. Murray, Jacksonville
- Appointment of Convention Committees
- Minutes of the Twenty-Sixth Annual Meeting, Mrs. Nelson A. Murray
- Convention Rules of Order, Mrs. Herschel G. Cole, Tampa
- In Memoriam, Mrs. S. Raymond Cafaro, St. Augustine
- Reports of the Officers and Committee Chairmen:
  - President-elect, Mrs. Richard F. Stover, Miami



Mrs. Thomas C. Kenaston
President, Woman's Auxiliary

- First Vice President, Mrs. Samuel S. Lombardo, Jacksonville
- Second Vice President, Mrs. Scottie J. Wilson, Fort Lauderdale
- Third Vice President, Mrs. Curtis W. Bowman, St. Petersburg
- Fourth Vice President, Mrs. James T. Cook Jr., Marianna
- State Project, Mrs. William D. Rogers, Chattahoochee
- Treasurer's Report including Auditor's Report, Mrs. Edward W. Cullipher, Miami
- Finance Committee, Mrs. Taylor W. Griffin, Quincy
- Student Loan Fund, Mrs. Ralph S. Sappenfield, Miami
- President's Report, Mrs. Thomas C. Kenaston

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Unfinished Business
New Business
Election of 1955 Nominating Committee
Address, Mrs. George D. Feldner, President, Woman's Auxiliary to the Southern Medical Association

Intermission (20 minutes)

Coca-Cola will be served during this time courtesy of the President and President-elect.

"Auxiliary Opportunities for 1954," Mrs. Leo J. Schaefer, President, Woman's Auxiliary to the American Medical Association
Election of Delegates to the National Convention
Report of Courtesy Resolutions Committee, Mrs. Scottie J. Wilson, Fort Lauderdale, Chairman
Report of Registration, Mrs. A. Fred Turner Jr.
Report of the 1954 Nominating Committee, Mrs. Herschel G. Cole
Election of Officers
Installation of New Officers, Mrs. Leo J. Schaefer
Presentation of Past President's Pin, Mrs. Herschel G. Cole
Presentation of the Gavel, Mrs. Thomas C. Kenaston
Inaugural Address, Mrs. Richard F. Stover

1:00 p.m. Luncheon — Sun Room
A special table will be reserved for all past state presidents.
"The Woman's Auxiliary in Public Relations," Dr. Edward Jelks, Jacksonville

9:00 p.m. Smoker — Hollywood Beach Hotel — Pool Patio

Tuesday, April 27

9:30 a.m. Post-Convention Board Meeting, Parlor 45: Mrs. Richard F. Stover, presiding. Members of the Board are officers, standing committee chairmen and county presidents. County presidents-elect and members-at-large are especially invited to attend.

7:00 p.m. Association Dinner — Main Dining Room



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(Continued from page 659)

SANDOZ PHARMACEUTICALS — 29

AMEDIC SURGICAL COMPANY — 30-31

To see new items which will be helpful to you and our patients, visit our Booths.

CENTRAL-ETHEX, INC. — 32

Central-Ethex, Inc., of Griffin, Ga., is sole distributor in the Southeastern states (Florida, Georgia, North Carolina and South Carolina) for Central Pharmacal Co., of Seymour, Ind. Its products are all strictly ethical, prescription products. In their booth at the Convention they will exhibit, Restrol (brand of dienestrol) the Synophylates (brand of theophyllin formulae) and Trisulfazine (the first Council-accepted trisulfa products), all Council-accepted. The exhibit will be in charge of Wm. G. Downs Jr., Ph.D., Sales Manager for the Company.

WHITE LABORATORIES, INC. — 33

WHITE'S "PHONOSCOPE" — enables you to hear some of the heart sounds commonly encountered in clinical medicine and to see graphically displayed the associated electrocardiograms, carotid artery pulsations and apical pethograms. GITALIGIN (amorphous gitalin) which has been described as a ". . . digitalis preparation of choice" will be on display.

AYERST LABORATORIES — 34

ROWLAND LABORATORIES — 35

WINTHROP-STEARNS INC. — 36

THE MEDICAL PROTECTIVE COMPANY — 37

Exclusive application to the field of Professional Liability Insurance endows The Medical Protective Company with a "know-how" in Defense Unlimited that distinguishes it from all others. It produces an enviable record which policyholders suffer no involuntary loss from their own pockets in malpractice suits. Thereby, Defense, rather than coverage limits, continues to prove the most effective protective factor.

HOFFMANN-LAROCHE INC. — 38

BROWN & WILLIAMSON TOBACCO CORP. — 39

GENERAL FOODS CORPORATION — 40-41
INSTANT SANKA COFFEE

It is a pleasure for General Foods to feature decaffeinated INSTANT SANKA COFFEE at the Eightieth Annual Convention of your Association. Won't you stop for your morning cup? And come back for "seconds" between meetings? We look forward to seeing you — one and all.

J. B. LIPPINCOTT COMPANY — 42

J. B. Lippincott Company presents, for your approval, a display of professional books and journals geared to the latest and most important trends in current medicine and surgery. These publications, written and edited by men active in clinical fields and teaching, are a continuation of more than 100 years of traditionally significant publishing.

THE UPJOHN COMPANY — 43

The Upjohn exhibit will feature CORTEF, brand of hydrocortisone. Reports from clinicians and practitioners reveal dramatic results in the use of CORTEF where cortisone is indicated. CORTEF is available in tablet or ointment form for oral or topical use. Upjohn representatives will welcome the opportunity to furnish additional information to the profession.

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ANDERSON SURGICAL SUPPLY CO. — 44

THE BAKER LABORATORIES, INC. — 45

You are invited to visit the Baker booth where Baker's Modified Milk and Varamel, two successful products for infant feeding, are on display.

Baker representatives will be glad to discuss with you the practical application of Grade A milk, adjusted fat composition, zero curd tension, synthetic vitamins and other important factors which help to eliminate many of the problems in modern infant feeding.

RITTER COMPANY, INC. — 46-47

Hundreds of physicians are finding routine examinations and treatments such as gynecology, proctology, urology, E.E.R.N.T., and all other phases of medicine, easier through using Ritter Motor operated "Multi-Level" Tables.

Let us show you and explain the many benefits derived from this investment in a lifetime of convenience and comfort for both doctor and patient.

CARNATION COMPANY — 48

MILES REPRODUCER COMPANY, INC. — 49

CASE HISTORIES, Lectures, Dictation may now l recorded at a 60-foot radius with WALKIE-RECORI ALL — an 8-lb., self-powered battery recorder-transcribe It operates in or out of the closed briefcase, indoors outdoors, while stationary, walking, riding or flying. Th Voice-activated "Self-Start-Stop" feature automatical starts and stops the recording from microphone or tel phone, thus eliminating supervision and the recording silent periods. While facilities for transcribing are avai able, transcriptions may be eliminated due to ease handling identifiable compact, indexed recordings witho the delay of rewinding. Up to 8 hours of permane recordings may be accumulated at intervals on an endle belt costing only 25 cents.

A. S. ALOE COMPANY — 50

A cordial welcome is extended to the members of th Florida Medical Association to visit the A. S. Aloe Com pany exhibit. A unique array of Surgical, Physio-The apy, X-Ray, and Laboratory equipment will be displaye

WALKER LABORATORIES, INC. — 51

PRECALCIN, PRECALCIN LACTATE, BACIMY CIN OINTMENT, SURGIMIN, SURGIMIN-T and th Council Accepted oral anticoagulant HEDULIN, will g top billing at the WALKER booth. The new PRECAI CIN LACTATE product is the same as the original PRE CALCIN except for the source for calcium which is th lactate instead of the phosphate. By providing bot forms, the doctor may have his choice of calcium sourc to suit individual patient requirements.

HART DRUG CORPORATION — 52



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Pharmaceutical Manufacturers

U. S. RADIUM CORPORATION — 53

RADELIN DIVISION of the U. S. Radium Corp. will exhibit a complete line of x-ray screens — intensifying, fluoroscopic and photoradiographic. The exhibit will include a new intensifying screen — High Resolution—which renders exceptionally sharp images.

McNEIL LABORATORIES, INC. — 54

Members of the Florida Medical Association are cordially invited to visit our booth, Mr. W. C. Aitken in charge. Products to be featured are Butisol Sodium, Syndrox Hydrochloride, Syntil, Algoson, Clistin Maleate, Butisol-Belladonna and Sustinex.

IVES-CAMERON COMPANY, INC. — 55

We are proud to exhibit MONICHOL, the first satisfactory medication for the normalization of elevated serum cholesterol levels as associated with cardiovascular disease, diabetes, etc. This and other laboratory findings have shown that MONICHOL exerts a favorable influence on cholesterol metabolism. Trained representatives will also be glad to discuss with you DUOTINIC, the non-constipating hematinic with the dovetailed formula; OXSORBIL and OXSORBIL-PB, indicated in the therapy of hepato-biliary disease; PABASYL, the modern antirheumatic; SOLUTHERA, the therapeutic water-soluble, polyvitamin capsule and our other pharmaceutical specialties.

BURROUGHS WELLCOME & CO. (U.S.A.) INC. — 56

'MAREZINE'® Hydrochloride brand Cyclizine Hydrochloride

Controls nausea and vomiting of pregnancy, motion sickness, vertigo and radiation sickness without inducing drowsiness.

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Eradicates pinworms. Pleasant to take.

'TRICOLOID'® brand Tricyclamol — Compressed, sugar-coated

New anticholinergic for relief of hyperacidity, functional diarrheas and gastrointestinal spasm.

J. A. MAJORS COMPANY — 57

The W. B. SAUNDERS COMPANY, Medical Publishers of Philadelphia, represented by their Southern Agents, J. A. MAJORS COMPANY, will occupy this space at the State Meeting. The doctors attending the meeting will find many new works on display, namely Conn's "Current Therapy 1954;" Mayo Clinic Volume 1953; Gross' "Surgery of Infancy and Childhood;" Bakwin & Bakwin "Clinical Management of Behavior Disorders in Children;" Haymaker's "Peripheral Nerve Injuries;" Sweet's "Thoracic Surgery," 2nd edition; Conant and others "Clinical Mycology," 2nd edition, and many others.

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From where I sit *by* Joe Marsh

Wish I'd Said That

You know Miss Perkins. Well, she's been driving her own car around our town for a little more than 30 years.

The other day she had a bit of trouble parking down on Main Street. Didn't quite make it the first try, so she pulled out to start over when a fellow waiting to pass started tooting his horn impatiently.

On the second try, she was still having a little difficulty, so this smart aleck behind her hollered, "Lady, do you know how to drive?" "Yes, young man," Miss Perkins answered, "I do. But I don't have time to teach you right now."

From where I sit, it's not always easy to have a good answer ready just when you need it. But when somebody tells me how to practice my profession, for instance, or to choose tea instead of a temperate glass of beer I like with dinner, I know the answer. We all have a right to our own ideas . . . and none of us like "backseat driving" from anybody.

Joe Marsh

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ABBOTT LABORATORIES — 58

BILHUBER-KNOLL CORP. — 59

Metrazol has been the subject of intensive investigatic in the past year. Information concerning the advantag of Metrazol as a vasomotor and respiratory stimulant, : well as a tonic, will be available. Your discussion (other Bilhuber products, such as, Dilaudid, Theocalc and Bromural, is also invited.

THE BORDEN COMPANY — 60

There's no better place to talk over the latest info mation on infant feeding than the Borden Prescriptic Products booth. On display is the complete line of Bo den's infant formula products for every feeding purpo or preference. You can feed almost any baby BREMIL MULL-SOY, DRYCO, or BIOLAC.

EISELE & COMPANY — 61

AMES COMPANY, INC. — 62

CLINITEST, for urine-sugar, is standardized. Th assures uniformly reliable results whenever and wherev a test is performed — office, ward, clinic, or patient home. Standardization not only curtails error, but sav personnel's time by elimination of preparing and mixir reagents.

ACETEST, for acetonuria, BUMINTEST for albun inuria, HEMATEST for occult blood, and ICTOTEST f urine bilirubin, will also be on display.

MEAD JOHNSON & COMPANY — 63

For almost fifty years, Mead Johnson & Company h served the Profession in the field of Infant Nutrition, ar is the only nutritional house having a complete line (Formula, Vitamins, and Cereals. These are represente by such nutritionally sound, Council accepted products : LACTUM, DEXTRIMALTOSE, POLY-VI-SOL, TR VI-SOL, and PABLUM.

HOLLAND-RANTOS COMPANY, INC. — 64

Physicians interested in Medical Contraception are co dially invited to discuss with H-R convention represen atives latest information on new clinical and laborato data concerning the efficacy of KOROMEX products.

BLAIR'S ASSOCIATE — 65

FLORIDA OXYGEN SERVICE — 66

The newest in inhalation therapy equipment will b on display at the Florida Oxygen Service Booth. Muc of this equipment was shown and demonstrated to Floric Oxygen technicians at the week-long meeting of the Inh lation Therapy Association in Chicago last Novembe conducted by some of the leading physicians in this speci field.

This equipment consists of the new Intermittant Pos tive Pressure Breathing Unit, Resuscitators with positiv pressure, and Nebulizers used for continuous high pe centage of humidity with water or Alevaire; the new oxy gen tent humidifier, plus masks, rebreathers and no rebreathers, which allow no CO^2 build-up in the rebreath ing bag.

Experienced technical men will be on hand at th Booth, with the apparatus and information on these new technics. All interested are cordially invited.

P. LORILLARD COMPANY, INC. — 67

P. Lorillard Company, manufacturers of OLD GOL and EMBASSY Cigarettes as well as BRIGGS Pipe Mi ture and other famous tobacco products will exhibit an demonstarte their new KENT Cigarettes with the exc sive Micronite Filter, which takes out up to 7 times mo nicotine and tars than other filter cigarettes.

SCHOETKER-THOMAS-KOCH X-RAY CO. — 68-69

U. S. VITAMIN CORP. — 70

SHARP & DOHME — 71

The many indications for 'Hydrocortone' or 'Cortone' highlight the therapeutic importance of these hormones in everyday practice. Research data relative to more effective therapy when penicillin is used in conjunction with 'Benemid' probenecid completes the exhibit. Expertly trained personnel solicit discussions on these observations.

SCHERING CORPORATION — 72

Members of the Florida Medical Association and their guests are cordially invited to visit the Schering exhibit where new therapeutic developments will be featured.

Schering representatives will be present to welcome you and to discuss with you these products of our manufacture.

BEECH-NUT PACKING COMPANY — 73

Have you used the BEECH NUT STRAINED AND JUNIOR FOODS for your GERIATRIC as well as your PEDIATRIC patients? Beech-Nut Nutritionists will be present to answer any questions you may have regarding the products available for special feedings.

PARKE, DAVIS & COMPANY — 74

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products of particular interest to members of the Association. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Oxycel, Thrombin Topical, Milontin, Amphedase, etc., will be featured. You are cordially invited to visit our exhibit.

VANPELT & BROWN, INCORPORATED — 75

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

WYETH LABORATORIES — 76

You are cordially invited to visit the display of Wyeth Laboratories, featuring various dosage forms of BICILLIN®, the new penicillin compound: Oral BICILLIN, Suspension and Tablets; BICILLIN Injections; BICILLIN Injection Long-acting; BICILLIN All-Purpose; BICILLIN C-R. Also ETHOBRAL®, new triple barbiturate capsules for rapidly induced, sound, prolonged sleep without hangover.





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WESTINGHOUSE ELECTRIC CORP., X-RAY DIVISION — 78-79

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They are well prepared to custom-plan your x-ray facilities for present and future use.

Westinghouse appreciates this opportunity to present our x-ray products to you at this meeting.

EATON LABORATORIES, INC. — 80

Furadantin® N.N.R., the new oral nitrofuran recently accepted by the Council, will be emphasized. Intended specifically and solely for bacterial urinary tract infections, it is producing excellent results, especially in such refractory infections as by Proteus.

New dosage forms of the topical antibacterial agent Furacin® will be displayed. These include Furacin Soluble Powder, for convenient, painless application to lesions — Furacin Nasal with Neo-Synephrine® — Furacin Urethral Suppositories for urethritis in women.

For control of conception when pregnancy is contraindicated, Lorophyn Suppositories N.N.R. offer a simple, dependable technic.

MEDICAL SUPPLY COMPANY — 81

Stop and visit the "Medical Supply Man."

A welcome from our representatives awaits at our Exhibit.

GUILD OF PRESCRIPTION OPTICIANS OF FLORIDA — 82

It is the purpose of the Guild of Prescription Opticians of Florida to advance the science of opthalmic optics through the development of a state-wide ethical optical dispensing service — a service that comprehensively meets the needs of the ophthalmologist and his patient. It is hoped that through the medical profession in general, to educate the public to the fact that the Ophthalmologist-Guild Optician type of eye service is the most desirable form of eye care. All of the members of the F.M.A. are cordially invited to visit us at our Booth.

EXECUTONE, INC. — 83

Executone Showing New Time-Saving Equipment for Doctors' Offices and Clinics.

Displayed at the Executone booth will be the latest equipment designed to save doctors and their staffs many steps and much time. The equipment expedites the flow of patients throughout the doctor's office thus enabling him to have a smoother-working organization in which more can be accomplished during the working day.

This booth will be manned by local representatives who will be glad to give full information on the equipment displayed.

R. J. REYNOLDS TOBACCO COMPANY — 84

Welcome to the CAMEL — CAVALIER Exhibit! You are cordially invited to receive a cigarette case (monogrammed with your initials) containing your choice of CAMELS, America's most popular cigarette, or CAVALIERS, the king size cigarette of extra mildness and distinctive flavor.

J. B. ROERIG AND COMPANY — 85

AUDIO-DIGEST FOUNDATION — 86

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Medical Director

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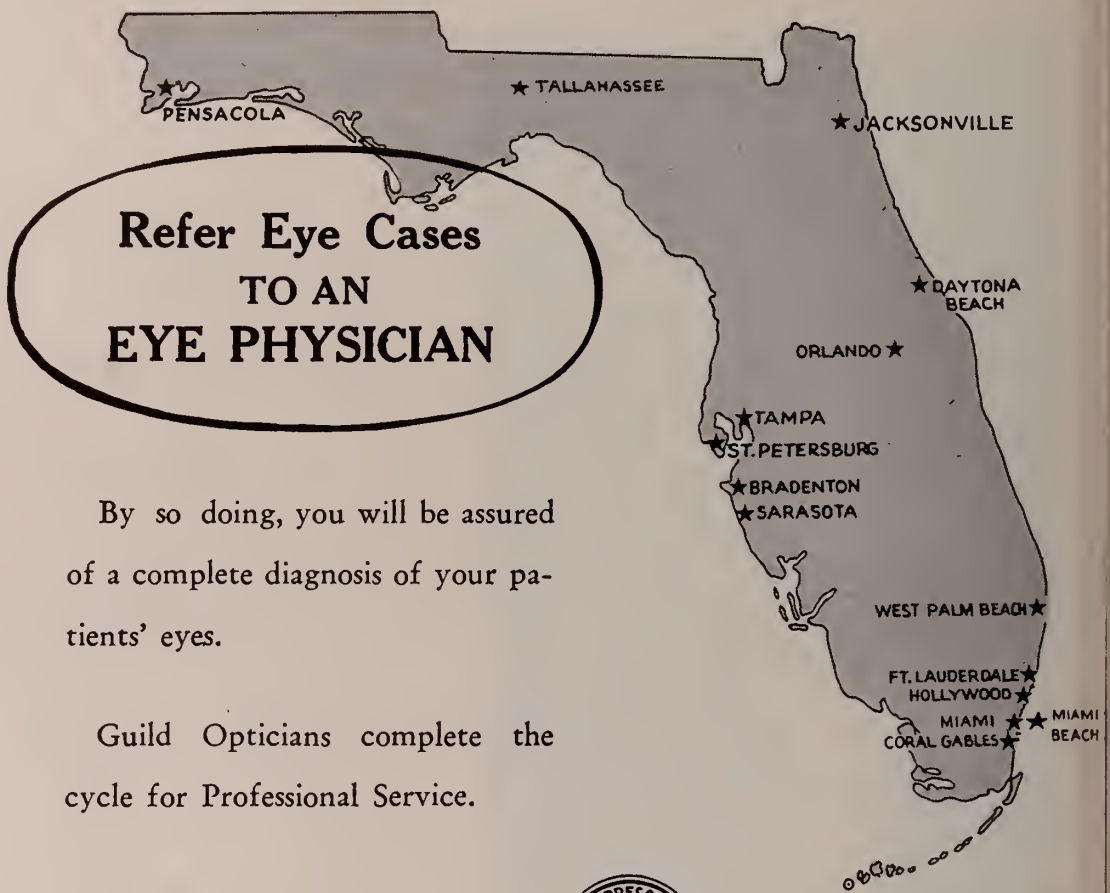
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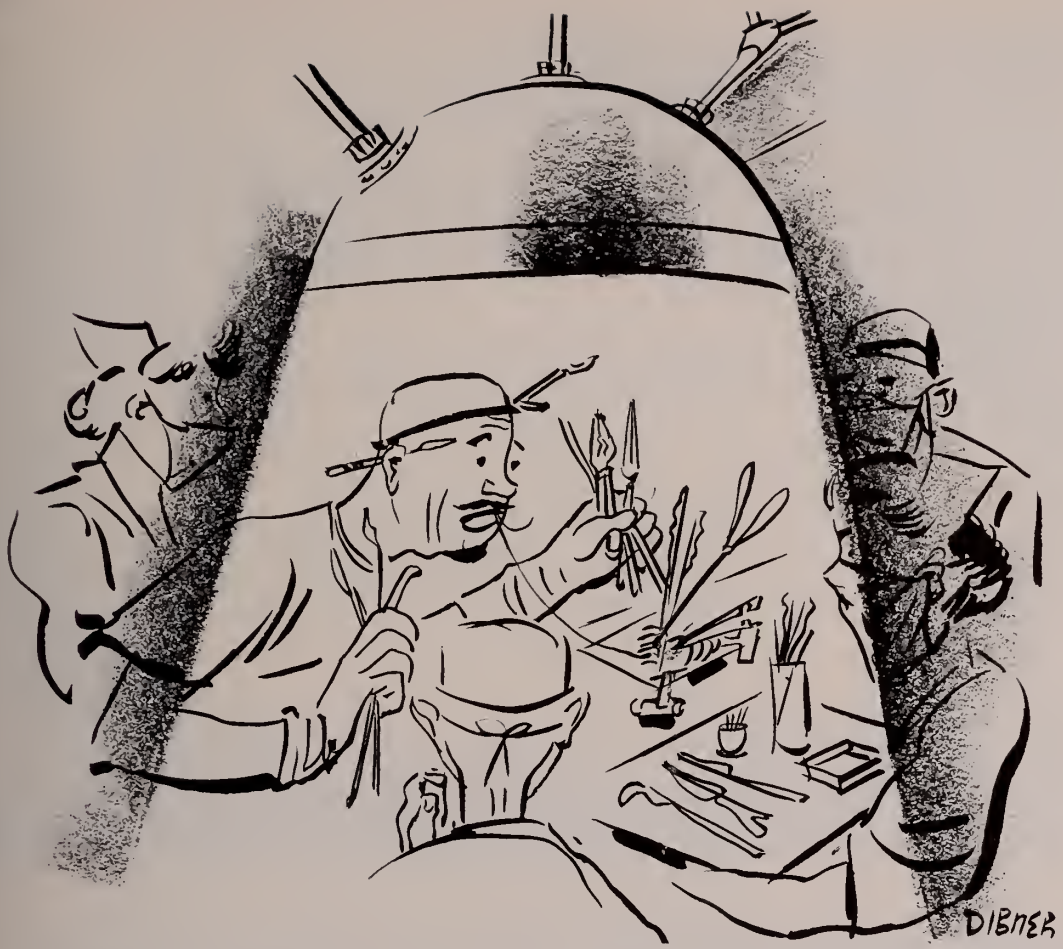
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	Harry H. Marsh	401 Langford Bldg.
Miami Beach	Louis Gillingham	630 Lincoln Rd.
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Daytona Beach	Harvey E. White	220 S. Beach St.
Pensacola	Bennie Barberi	18 W. Garden St.
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Tallahassee	Julian Jackson	105 College Ave.
Sarasota	Oscar Loewe	Main St.
Bradenton	James T. Lynn Jr.	1021 Manatee Ave., W.
West Palm Beach	H. T. Sait	320 Datura St.
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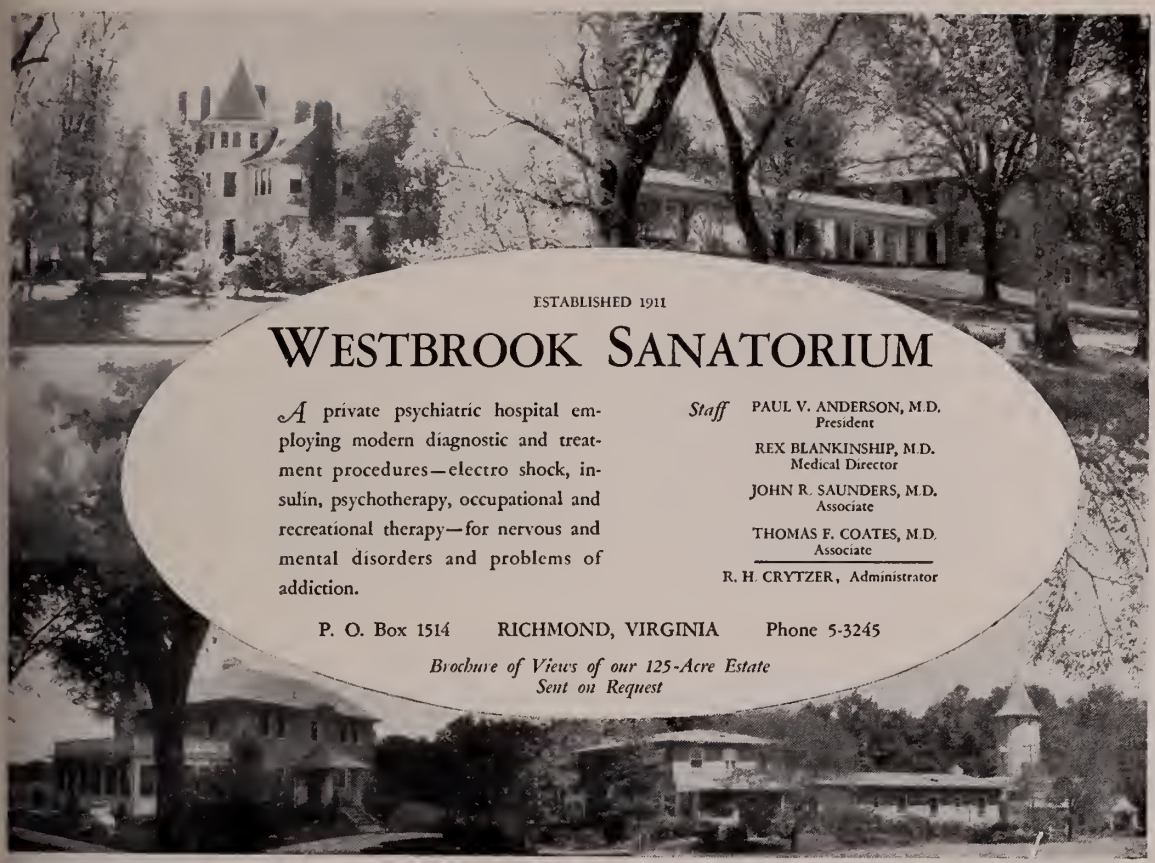
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Little River	8340 N.E. Second Ave., Suite 245	Jacksonville	303 Clark Building
Miami Beach	206 Harvey Building	Tampa	228 Cass Street Arcade Building
Hialeah	1210 Pacific Bldg.	Sarasota	1369 Main Street, Room 15
St. Petersburg	509 White Building	Daytona Beach	116½ Orange Avenue
Lakeland	206 Marble Arcade	Pensacola	501 Theisen Building
West Palm Beach	305 Citizens Building		



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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
a Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
a Medical Districts	John D. Milton, Miami	Council Chairman	
orthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
ortheast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
outhwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
outheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
a Specialty Societies			
ny of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	Hollywood, Apr. 25, '54
Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
esiologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
r, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
and Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
rial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
ogy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
l Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
l. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
edic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	" "
ogists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	" "
ic Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
ogic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	" "
ogical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	Hollywood, Apr. 24-25, '54
ical Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	Hollywood, Apr. 25, '54
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
d Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	Hollywood, Apr. 25, '54
er Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
al Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
al Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, Apr. 25-28 '54
t Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	Miami, Apr. 29-May 1, '54
ital Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
cal Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
cal Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, July 12-16, '54
e Anesthetists, Fla. Assn.	Miss G E. Keyes, Daytona Beach	Mrs. Lillie Crouch, Daytona Beach	Atlanta, April '54
s Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
naceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May 10-12 '54
c Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
eau Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	St. Petersburg, Apr. 9-10, '54
rculosis & Health Assn.	Leffie M. Carlton Jr., Tampa	Mrs. L. C. Conant, Fort Myers	" "
n's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers Jr., Cocoa	Hollywood, Apr. 25-28, '54
n Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
A Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 30-Dec. 3, '54
n Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
n Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
Medical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
spital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
stern Allergy Assn.	W. Lindsay Miller, Gadsden, Ala.	Kath. B. MacInnis, Columbia, S. C.	Atlanta, Mar. 25-27 '54
stern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
stern Surgical Congress	J. R. Young, Anderson, S. C.	B. T. Beasley, Atlanta	Birmingham, Mar. 8-11, '54
ast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22, '54

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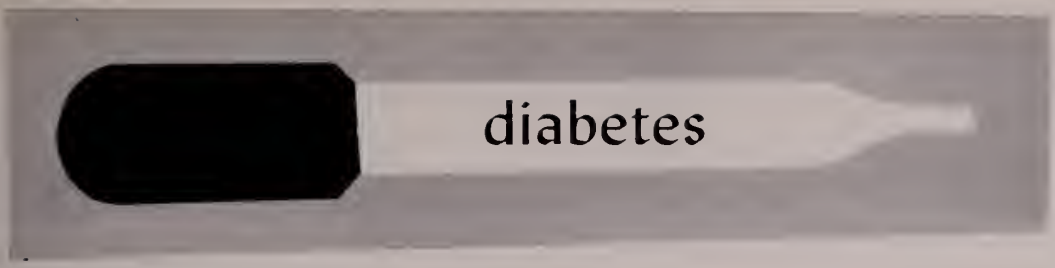
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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	47
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James M. Nixon, Panama City	1st Tues.	23
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	26
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	97
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	622
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	253
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	94
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	6
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	177
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	6
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	25
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	31
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	51
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	21
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	26
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	13
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	166
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	128
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	183
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	89
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	9
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	16
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	16
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	48
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	8
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	75
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	15
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		4
			Total	2,385

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1. Blotner, H., and Marble, A.: New England J. Med. *245*:567 (Oct. 11) 1951.
2. Steine, L.: GP *8*:45 (July) 1953.

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Sidney Davidson

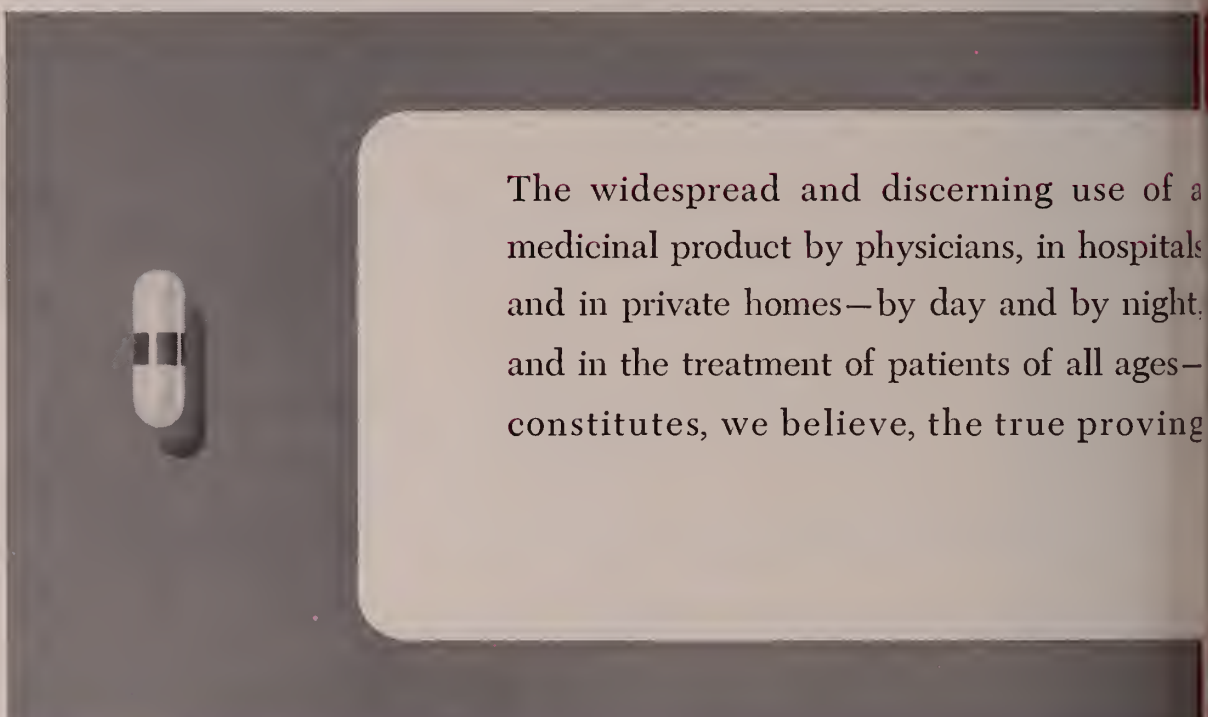
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Robert H. Nickau, Herbert L. Corse, and John F. Ivey

Management of Asthmatic Patient
Maurice Kovnat

Screwworm Infestation in Humans
William H. Turnley

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Volume XL APRIL, 1954 No. 10

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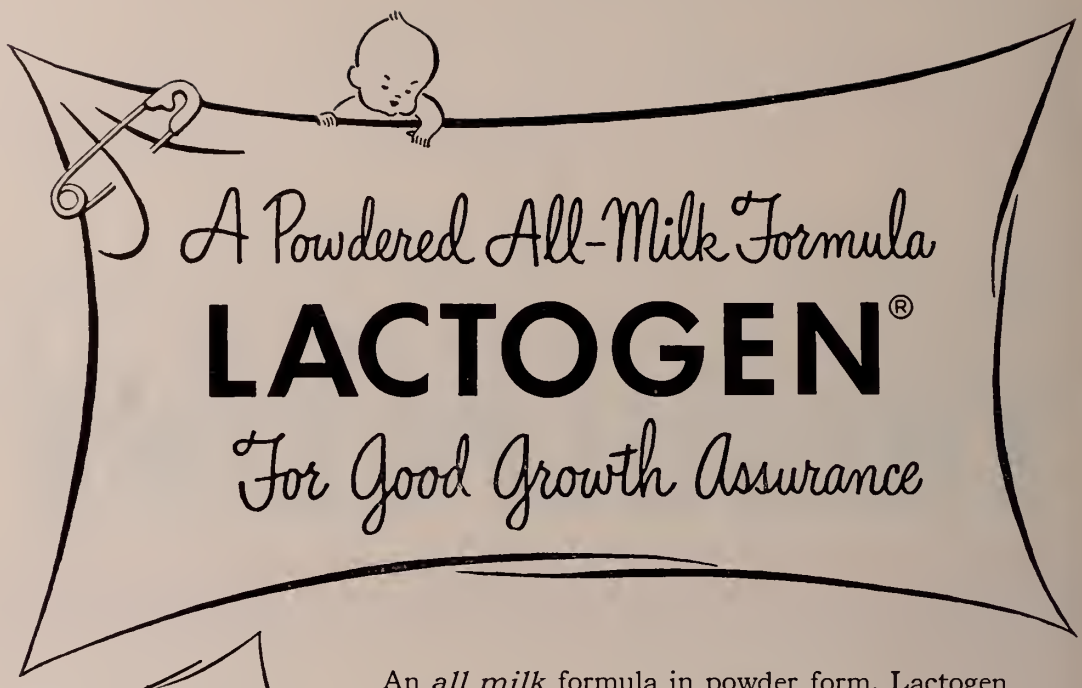
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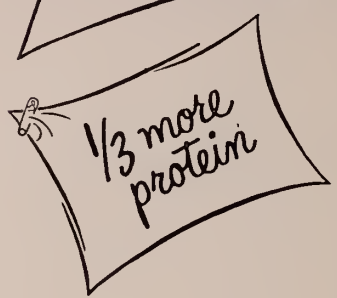
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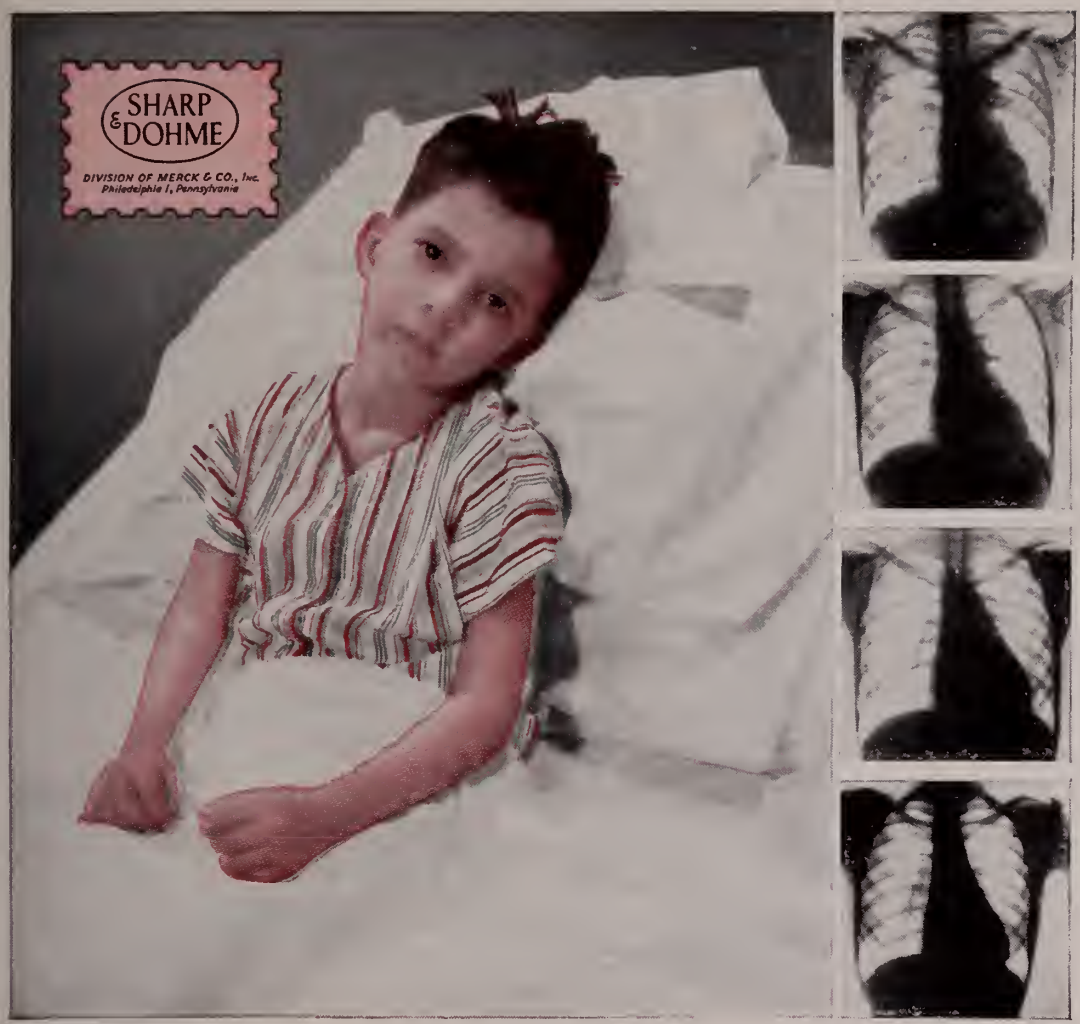
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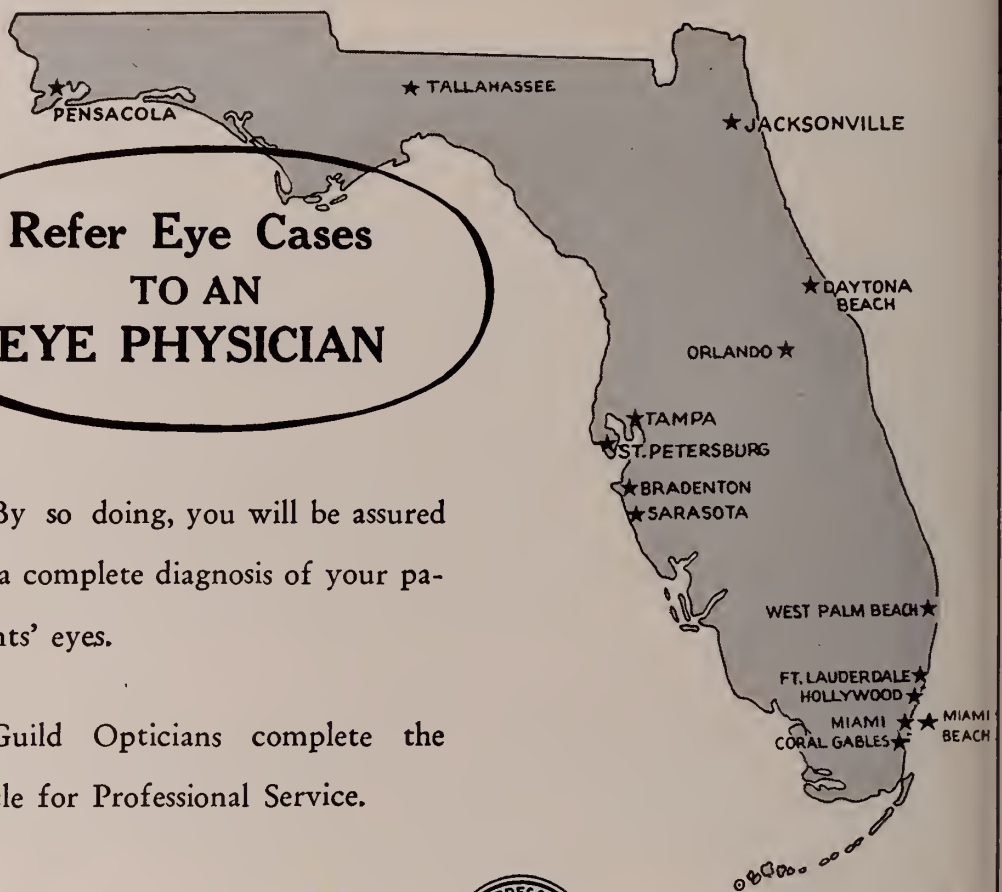
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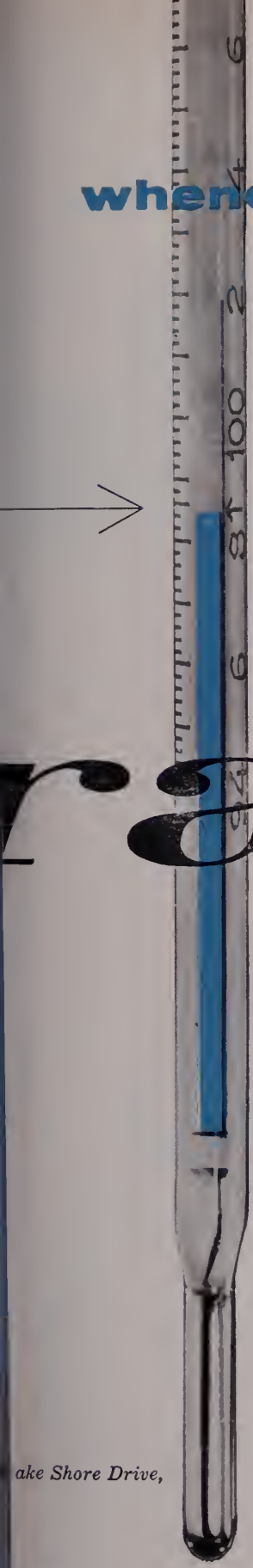
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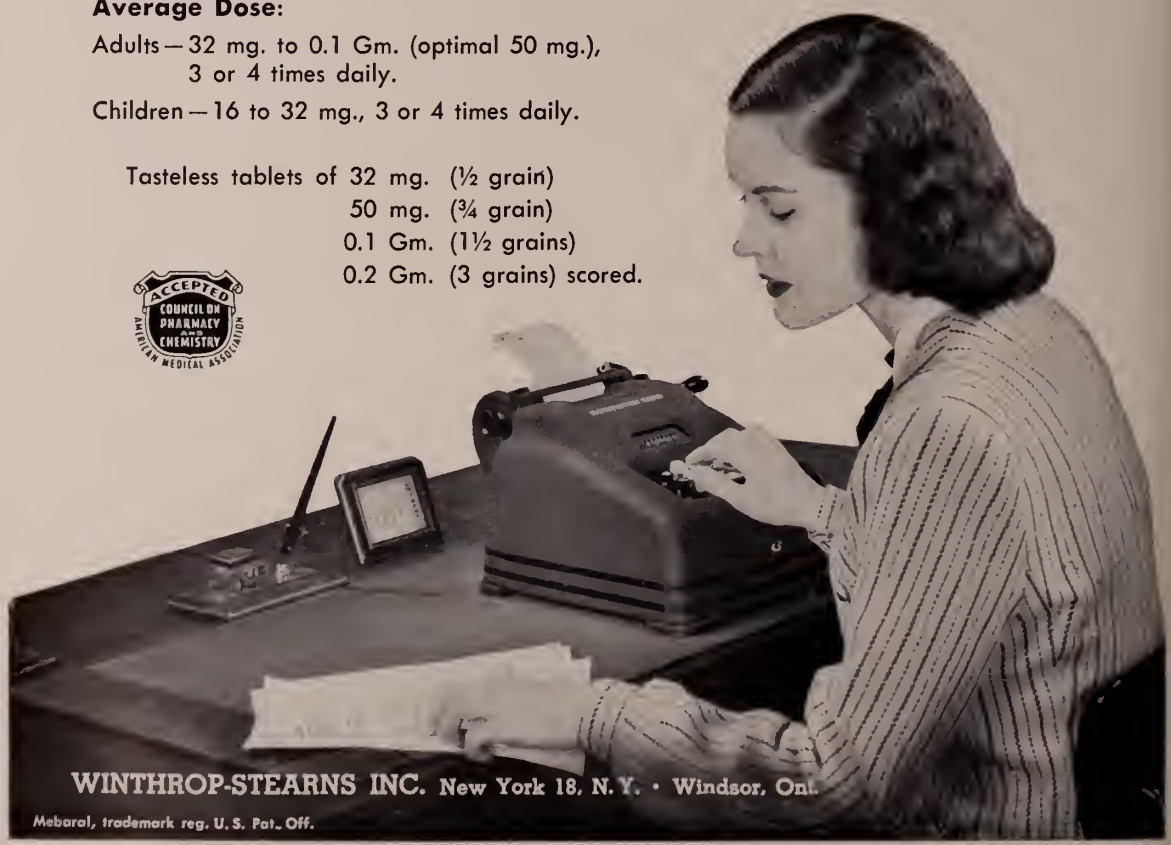
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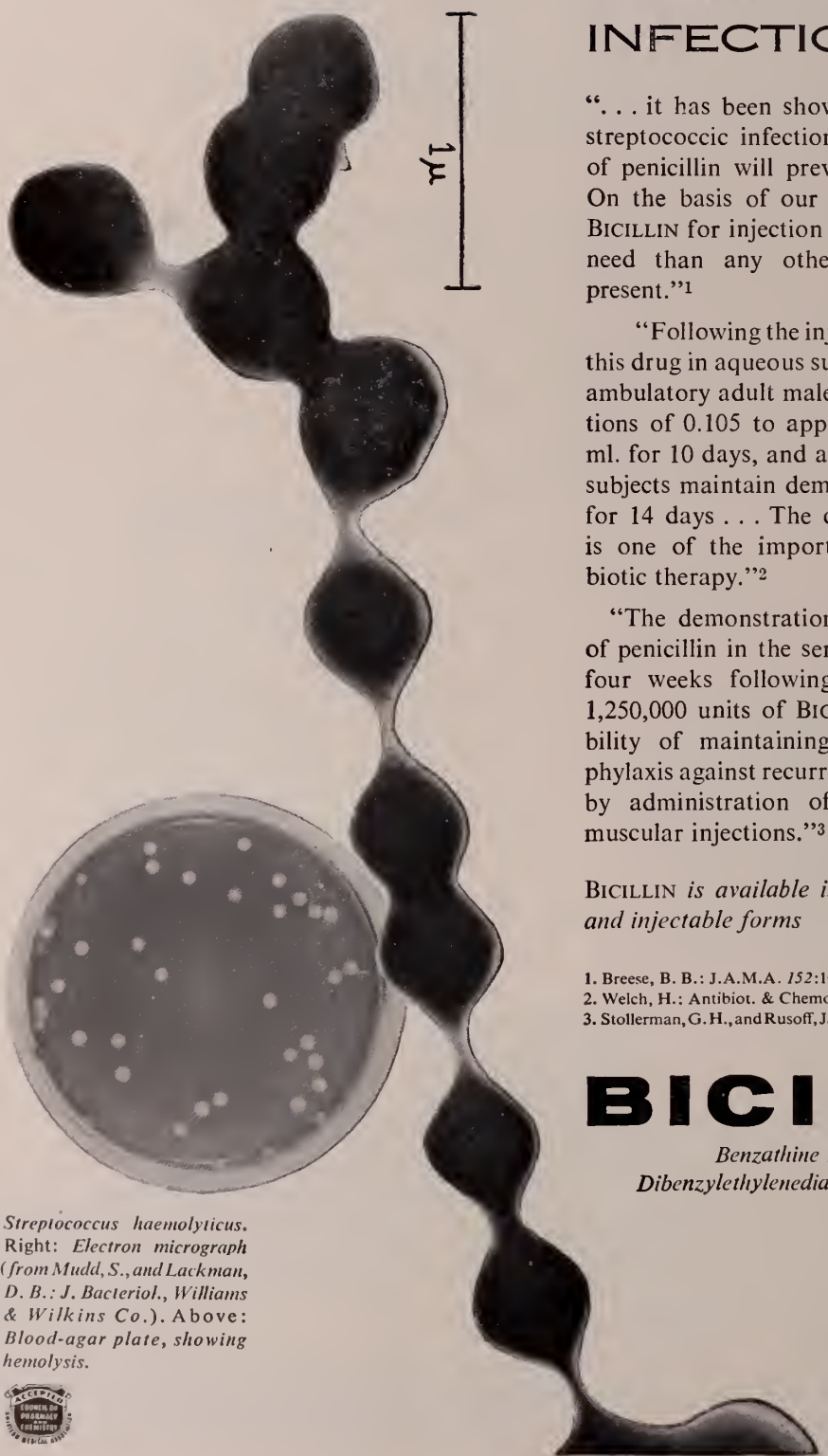
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The Use of Vitamin B_{12} in the Treatment of Diabetic Neuropathy

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LAKE WORTH

The association of a characteristic disorder of the peripheral nervous system with diabetes mellitus has been known and described since 1864.[1] From that time until now, many and various have been the theories which have been advanced as to the etiology of this disorder. Arteriosclerosis, always associated with diabetes as a major complication, has many times been indicted as the major and sole cause for the neuropathy when it involves the peripheral nervous system.[2, 3] The experimental work of Roberts[4] suggests the role played by occlusive lesions of the vasa nervorum upon peripheral nerve disorders as the means through which diabetic vascular disease results in diabetic neuropathy. It has been suggested by others that the lesion is a result of vitamin B deficiency.[5, 6] Despite all the efforts, however, that have been made to find a specific cause, the present consensus seems to be that diabetic neuropathy results from the abnormal metabolism of poorly regulated diabetes, despite the fact that the disorder not infrequently occurs in patients in whom seemingly the diabetes is under good control.[7, 8]

The incidence of this disorder is surprisingly high. It has been variously reported as 85 per cent.[9] 82 per cent[8] and 70 per cent.[10] In my practice it is somewhat lower, being 55 per cent.

Various attempts at specific therapy have been made. The use of vitamin B complex or of large amounts of its components has been tried repeatedly with no real evidence of appreciable effect. Of late, however, success has been reported in the use of vitamin B_{12} by some observers[11, 12] and the use of an extract of liver of pregnant mammals by others.[9, 13]

Sancetta, Ayres and Scott[11] used vitamin B_{12} the treatment of diabetic neuropathy because of its effectiveness in the treatment of the neurologic complications of pernicious anemia, despite the fact that they considered the similarities between the two conditions for the most part superficial. They treated 12 patients for whose neurologic complaints no cause could be found other than the diabetes. They used crystalline vitamin B_{12} parenterally for periods from three to 13 months. All these patients had absent or diminished patellar reflexes, hypesthesia and paresthesias. Many had loss of temperature discrimination of the extremities and some were ataxic. Other manifestations of diabetic neuropathy were also encountered in these patients. Of the 12, 7 had been followed for a long time previous to the administration of vitamin B_{12}. Their neurologic problems had been comparatively of long standing and seemingly were unaffected by what appeared to be good diabetic control. In the remaining 5 the diabetes seemed to be inadequately controlled, but was in the process of being controlled while the vitamin B_{12} therapy was being administered. The results in this series were good. In both groups the paresthesias and shooting pains disappeared. The hypesthesia was no longer present, and the loss of temperature discrimination was alleviated. In some cases there was some improvement in patellar reflexes. When vibratory sense perception was impaired, it did not return.

In view of the good results reported by these authors, a group of 12 patients with known diabetic neuropathy was treated with vitamin B_{12}. Of the 12, only 5 could be followed closely enough to allow for adequate evaluation of the results of the therapy. In 3 of these 5, there was good diabetic control throughout. In 1, the disease was not considered under adequate control for any appreciable length of time during the period of

Read before the Florida Clinical Diabetes Association, First Annual Meeting, St. Petersburg, May 14, 1953.

Table 1. — Summary of Effect of Vitamin B_{12} Therapy

Patient	K. P.		C. O.		C. B.		V. G.		W. K.	
	Before	After	Before	After	Before	After	Before	After	Before	After
Lightning pains	None	None	Present	None	Present Severe	None	Present	None	Moderate	None
Paresthesias	Moderately severe	None	Moderately severe	None	Severe	None	Moderate	None	Moderate	None
Hypesthesias	Moderately severe	Moderately severe	Moderately severe	Moderately severe	Moderately severe	Moderately severe	Moderate	Moderate	Moderate	None
Vibratory sense	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent	Absent
Temperature Discrimination	Diminished	Diminished	Diminished	Diminished	Diminished	Diminished	Diminished	Diminished	Diminished	Diminished
Patellar reflexes	Absent	Absent	Present	Present	Present	Present	Present	Absent	Absent	Absent
Diabetic control	Good	Good	Good	Good	Poor	Poor	Good	Good	Poor	Good
Period of therapy	Five months		Six months		Five months		Six months		Four months	

observation and had been under poor control until the administration of the vitamin B_{12}, but was brought under control during that period. The dose of vitamin B_{12} given was constant throughout. Thirty micrograms of crystalline vitamin B_{12} was administered parenterally three times a week. In none of these cases was there evidence of any hematologic disorder.

Table 1 summarizes the data which I thought adequately showed the effect of the therapy on some of the significant signs and symptoms of the disorder. The following are brief histories of these 5 cases:

Report of Cases

Case 1. — Mr. K. P., a 56 year old man with diabetes, complained on Jan. 8, 1952 of stiffness of the knees and ankles and numbness of the feet. The diabetes had been under good control for the past three years. He had had several severe episodes of diabetic neuritis which had responded only indifferently to vitamin B complex. The stiffness and numbness were of one year's duration. Neurologic examination revealed hypesthesia of the left leg and ankle. There was complete loss of vibratory sense in both great toes. Temperature discrimination was markedly impaired in both lower extremities below the knees. The patellar reflexes were absent bilaterally.

He was given 30 micrograms of vitamin B_{12} three times weekly and by January 23 stated that the numbness and stiffness were diminished. The objective findings, however, were unchanged. The numbness and stiffness diminished more and more, and when the patient was seen on June 28, these symptoms were no longer present. Physical examination, however, revealed that no significant changes had taken place in the objective evidences of the neuropathy. The patellar reflexes were still absent, hypesthesia in the left lower extremity was still present, vibratory sense was still absent, and temperature discrimination was markedly impaired.

In this case of well controlled diabetes, after five months' administration of vitamin B_{12}, there were no longer any subjective complaints referable to the nervous system, but the objective findings of diabetic neuropathy were essentially unchanged.

Case 2. — Mrs. C. O., a 64 year old white woman, had been known to have diabetes since 1948. The disease was mild and had apparently been under good control throughout this illness. When the patient was seen in September 1951, it was under good control, but she was complaining of numbness in both feet. There was an occasional shooting pain in both lower extremities, especially at night. There was no hypesthesia, but there was diminution in temperature discrimination and loss of vibratory sense. The patellar reflexes were present. She was given vitamin B_{12}, 30 micrograms three times a week. The numbness and the shooting pains responded, and by June 13, 1952 they were gone. The patellar reflexes were still present, but the loss of temperature discrimination and hypesthesia were unchanged. Vibratory sense was still absent.

Here again is a case of fairly well controlled diabetes with both subjective and objective evidence of diabetic neuropathy. After six months of vitamin B_{12} therapy, the subjective complaints vanished, but there was no appreciable change in the objective neurologic findings.

Case 3. — Mrs. C. B., a 64 year old white woman with diabetes, had been followed since 1947. The disease had not been under good control at any time during that period as she neglected her diet and was taking insulin in a hit or miss fashion. She had been known throughout that period to have severe vascular changes in the eye-grounds, moderate hypertension and hypertensive heart disease. She had been complaining intermittently from 1947 until January 1952 of severe knifelike pains in the legs, numbness and tingling. On examination, although there was obvious evidence of vascular disease in the eye-grounds, and an electrocardiogram showed great myocardial damage, the pulses were good in both lower extremities. Neurologic examination revealed hypesthesia and loss of temperature discrimination in the left lower extremity below the knee. There was loss of vibratory sense in both great toes. The patellar reflexes were equal and normal. She was given vitamin B_{12}, 30 micrograms three times a week. During the ensuing six months, there was no change in the control of the diabetes. She did not adhere to a diet although she did take insulin regularly. She claimed to be aglycosuric most of the time, but urine tests were performed infrequently. Fasting blood sugar determinations ranged from 216 to 292. On March 1 she stated her feet were much better and the pains in her legs were gone. The severe pain, numbness and tingling had completely vanished by June 3. The objective evidences, however, were unchanged. The hypesthesia and loss of temperature discrimination were still present. There still was no perception to vibration. The patellar reflexes, which had been present, were still present and unchanged.

In this case of somewhat uncontrolled diabetes, the patient was given considerable relief from the discomfort of diabetic neuropathy. The objective evidences of the neuritis, however, after six months seemed unaffected.

Case 4. — Mr. V. G., a 60 year old white man, had been known to have diabetes since 1946. When he first consulted me on June 4, 1951, he had not been following any specific diabetic regimen. Most of his symptoms at the time were referable to the nervous system and involved the vasomotor system and gastrointestinal systems as well as the peripheral nervous system. The diabetes was rather readily controlled and most of the symptoms were those involving the peripheral nervous system. These consisted of occasional severe knifelike pains in the legs and thighs. They were much worse at night. They had been present previously, but were much diminished. There were also numbness and tingling of considerable degree in both lower extremities.

Neurologic examination at that time revealed a diminished patellar reflex on the right side. None was present on the left. There were pronounced hypesthesia and loss of temperature discrimination in both lower extremities. He was given 30 micrograms of vitamin B_{12} three times a week. The diabetes remained under control, and he gained weight. The pains in the legs and feet diminished and then disappeared. The numbness also vanished. When he was examined on June 30, however, the hypesthesia was unchanged, vibratory sense was still absent, and temperature discrimination was still poor. Neither patellar reflex could be elicited.

In this case there was alleviation of the pain and discomfort of diabetic neuropathy under vitamin B_{12} therapy. The objective findings of neuropathy nevertheless remained unchanged. It should be noted that the subjective complaints had been diminished prior to administration of vitamin B_{12} as a result of more satisfactory control of the diabetes. Whether the vitamin B_{12} therapy or more satisfactory control of the diabetes was responsible for the subjective improvement is problematic, but neither was able to affect the objective findings.

Case 5. — Mrs. W. K., a 73 year old white woman, was known to have had diabetes for 12 years. The disease had not been under good control when she was first seen in April 1951. From that time until January 1952, although she was under observation, the disease was not under good control. Throughout that time, she was complaining of sharp knifelike pains in the arms and legs, worse at night, and numbness in the lower extremi-

ties. Examination revealed moderate hypesthesia, loss of vibratory sense in both great toes and loss of temperature discrimination. The patellar reflexes were absent bilaterally. She was given 30 micrograms of vitamin B_{12} three times a week. Three months later the complaints were gone. The diabetes had been under better control. There no longer was hypesthesia, but vibratory perception was still absent. Temperature discrimination was still diminished, and the patellar reflexes were absent.

This case affords another instance of disappearance of the subjective complaints while the objective evidence remains, for the most part, unchanged. The diminished perception to light pin prick was reversed, however. Whether this was a result of the better control of the diabetes or the administration of the vitamin B_{12} cannot be determined.

Discussion

The use of vitamin B_{12} and of the extract of the livers of pregnant mammals is purely empiric with no particular rationale. Although the use of vitamin B_{12} in the neuropathy of addisonian anemia is well established, the pathology is not the same as that in diabetic neuropathy.[14] In pernicious anemia the large heavily myelinated neurones which conduct motion and position sense are involved, in contrast to the small poorly myelinated neurone in diabetic neuropathy. Vibratory sensibility is first affected, and pain is rarely a significant complaint in pernicious anemia while it is extremely common in diabetic neuropathy. In pernicious anemia, in addition to the peripheral neuritis, there is a characteristic lesion in the posterior and lateral columns of the spinal cord. Such a lesion is not present in the neuropathy of diabetes.

It should be noted that in the cases presented, just as in those reported by Sancetta and his associates,[11] the vitamin B_{12} apparently was able to relieve completely only the subjective complaints. This was also the result in the reported cases in which liver extract of pregnant mammals was used.[9, 11] I was not able, however, to observe in my cases the reversal in the objective findings found by Sancetta and his associates.[11] It may be noted that in those cases, although there was reversal of the objective findings, the relief of the subjective complaints was much more striking, as was also true in the cases treated with the liver extract from pregnant mammals.[9, 13]

As has been noticed before, I know of no reason why vitamin B_{12} should be of any assistance in diabetic neuropathy. The successful use, however, of vitamin B_{12} in painful neuropathies of other etiology besides that of addisonian anemia has been reported.[15] Vitamin B_{12} given in painful neuropathies of varied etiology did result in diminution of the severe lancinating pains and paresthesias.

The use of vitamin B_{12} in the cases reported did not seem to have any beneficial effect besides that on the neuropathy. When retinitis or other vascular complications were present, they seemed unaffected.

There is the possibility, of course, that the relative lack of effect of vitamin B_{12} in this series may be due to the fact that the lesions were a result of diabetic vascular disease rather than purely metabolic in origin. The uniform and in some cases rapid disappearance of the subjective symptoms, however, and the fact that in most of the cases there was no evidence of vascular disease involving the lower extremities make that unlikely.

Despite the seeming benefits of the administration of vitamin B_{12} in these cases, the lack of conclusive objective evidence has made me dubious as to whether or not there is a significant effect. The administration of the vitamin is a simple enough procedure and thoroughly innocuous. For this reason, I am continuing its use in all cases of diabetic neuropathy. I have no personal experience with the use of injections of liver extract from pregnant mammals.

Summary

In 5 cases of diabetic neuropathy the patients were treated with crystalline vitamin B_{12} for periods ranging from three to six months. They were given 30 micrograms three times a week.

In all cases there was alleviation of the subjective complaints, but the objective neurologic findings were essentially unaltered.

No definite conclusions as to the actual effectiveness of vitamin B_{12} on diabetic neuropathy could be drawn.

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The Use of Intravenous Procaine in Acute Myocardial Infarction

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Herbert L. Corse, M.D.
and
John F. Ivey, M.D.

Jacksonville

There has been widespread use of procaine solution intravenously in a variety of clinical conditions. Procaine was originally synthesized by Einhorn in 1905 and since that time has been a favorite agent for local injection anesthesia. Until the past few years, the intravenous administration of procaine was tantamount to a fatal accident. Sufficient experience with the drug, however, has shown it to be safe if administered under close medical supervision by physicians acquainted with its characteristics. Following its intravenous injection, it is destroyed by a procaine esterase in the plasma and the liver by breakdown into para-aminobenzoic acid and diethylaminoethanol.

By the formulation of a technic for the microdetermination of blood levels,[1] it was shown that procaine hydrochloride disappears rapidly from the blood stream in experimental animals and human beings. Jacoby and his associates[2] showed that intravenous procaine produces no damage to the liver, spleen, heart, and kidney in massive doses. Liver function tests on humans receiving physiologic doses intravenously failed to reveal any damage. Graubard, Kovacs and Ritter[3,4] established that it produces no change in the pulse, blood pressure, blood counts, and sedimentation rate or blood chemistry. Graubard and Spaulding[5] found no evidence of sensitivity or addiction to the drug in over 6,000 infusions. There was no morbidity nor mortality in their series.

Action on the Heart

Many studies have been made to determine the action of procaine on the heart. The effects of intravenous procaine depend on the speed of injection, the total dose administered, and the concentration of the solution used. Working with dogs, Long, Oppenheimer, Webster and Durant[6] reported that intravenous procaine causes the following cardiac changes: (1) Doses between 10 and 15 mg. per kilogram of body weight cause changes in the height of the R wave, in the T wave, and in the ST segment of the electrocardiogram. (2) Increasing the dose produces successively, bundle branch block, some slowing of conduction through the auriculoventricular node, ventricular tachycardia, and ultimately ventricular fibrillation. (3) As the bundle branch block increases, the force of the contraction of the heart is decreased. The cardiac changes short of ventricular fibrillation are usually reversible if respiration is maintained. Doak and Selke[7] reported that procaine in the concentration of 1 Gm. per 500 to 1,000 cc. given intravenously over a two to three hour period did not materially affect the electrocardiogram of humans and concluded that this was a relatively safe procedure.

Atanackovic and Dalgaard-Mikkelsen,[8] studying the physiologic action of procaine, concluded that the procaine paralyzes the parasympathetic and later the sympathetic synapses, and suppresses

the nicotinic and muscarinic effects of acetylcholine on the heart, but not the muscarinic effect of acetylcholine on the blood vessels. They also reported that procaine protects against most symptoms of intoxication by physostigmine and that physostigmine suppresses the paralyzing effects of procaine on synapses, postsynaptic cardiac innervation, and neuromuscular junctions.

Mautz[9] in 1936 reported a reduction in the irritability of the myocardium and conduction system of the heart by the topical application or intravascular injection of procaine. Wedd and Blair,[10] using turtles, found that procaine prolonged the conduction time in the ventricle and raised the threshold for stimulation. They also found that procaine caused a greater rise in threshold and greater prolongation of conduction time than did quinidine without the decrease in contraction strength that occurs with comparable concentrations of quinidine. Burstein[11] and Kraft[12] confirmed the value of intravenous procaine for the correction of cardiac arrhythmias associated with cyclopropane anesthesia. In the study of Stutzman, Allen and Orth,[13] however, procaine failed to reverse the cyclopropane-epinephrine induced ventricular fibrillation in dogs. Harris and his associates,[14] using dogs, also found intravenous procaine of little value in the control of ectopic ventricular tachycardias with induced myocardial infarction.

Purpose

There are no reports known to us of experience with intravenous procaine in acute myocardial infarction in humans. The effects of procaine upon the conduction system and the myocardium have been stated. It is also known that procaine produces arteriolar vasodilatation. Surrounding the area of necrotic muscle in myocardial infarction is an area of injured myocardium in the state of relative ischemia resulting from reflex arteriolar constriction. This ischemic or injured area produces the "current of injury" seen in the electrocardiogram. It was hoped that procaine could relieve, or partially relieve, the ischemia of the injured muscle by causing vasodilatation in that area, thereby lessening the extent of damage and speeding recovery. Beck and Mautz[15] pointed out that ischemic zones of heart muscle are often hyperirritable and act as trigger zones to produce arrythmias.

Method

At the Duval Medical Center, in a series of 18 consecutive cases of recognized myocardial infarction of less than 16 hours' duration the patients were treated with intravenous procaine hydrochloride, 500 cc. of a 0.2 per cent solution being administered every 12 hours for three days. The first 150 cc. was given in 20 minutes with the remainder by slow drip over an additional two hour period. All other medication was withheld if possible, but at times morphine, oxygen, sedation, or digitalis was required as a life-saving procedure. In one case pulmonary infarction was suspected, and in another thrombophlebitis developed, in which instance Dicumarol was used. We attempted to keep the patient at bed rest for a period of three to four weeks.

Results

In evaluating the results of treatment, it should be recognized that the patients were admitted through the emergency room of a busy charity hospital. These patients would often be in poor health prior to their illness, many of them would not report except if extremely ill, and when they were on the wards, no private rooms or special nursing care was available. Of the 18 patients, 14 were white, 5 of whom were women and 9 men. There were 2 Negro men and 2 Negro women. This series significantly demonstrates the disparity in incidence of myocardial infarction in Negroes and white persons, as the Negro services in this hospital are much the busier. The ages ranged from 39 to 84 years with an average age of 60.6 years. Seven patients had had previous myocardial infarctions, and 4 patients were receiving digitalis at the time of their infarction. Only one of these digitalized patients did not give a history of a previous myocardial infarction.

Following the administration of procaine, it was noted that the pulse, when either rapid or slow, tended to return toward normal. The effects on the systolic blood pressure after the first procaine infusion were a change of 10 mm. or less in 6 cases, an increase of more than 10 mm. in 7 cases and a decrease of more than 10 mm. in 5 cases. There was no lowering of the blood pressure to shock levels in any of these 5 cases in which the blood pressure was depressed with the first infusion. The lowering of the blood pressure in these cases may have been due to the natural hypotensive course of the disease in the first few hours rather than the vasodilating effect of the

drug, especially when cases 1, 2 and 8 demonstrated the reversion of a hypotensive state to normotensive with one infusion of procaine. In all 3 of these cases treatment was started within an hour of the acute episode. In cases 10 and 18 there was no obtainable blood pressure, and norepinephrine was administered intravenously along with the procaine. In case 16 the blood pressure dropped to 90 systolic and 60 diastolic during the second treatment, but returned to 120 systolic and 80 diastolic when the rate of infusion was slowed. This same patient tolerated five other infusions well. No other unusual blood pressure responses were noted.

In spite of the necessity of morphine in some cases, we attempted to evaluate the relief of anginal pain by the procaine. This varied from no relief to rather great relief in a few cases. The analgesic action in most cases, however, was mild to moderate and should not be relied on as a substitute for morphine. The hypothesis advanced by Graubard and Ritter[4] for the analgesic power of procaine is that an increased concentration of the drug is present in areas of trauma and inflammation due to increased capillary permeability. Keats, D'Allessandro and Beecher,[16] however, believed that it is more likely that the analgesia results from its action on the central nervous system, indicating that the systemic absorption of procaine alters the psychic reaction to painful stimuli.

Due to the urgency of the situation, it was impossible always to obtain an electrocardiogram prior to the first infusion of procaine. If it was not obtained at this time, however, 12 lead tracings before and immediately after subsequent infusions were made at least once on all patients. It would be superfluous to publish all the electrocardiograms on all these patients considering that even without procaine there are liable to be changing patterns of the electrocardiogram following an acute myocardial infarction. It is also common experience seeing the electrocardiogram improve on a patient following an infarction only to have him die the next day.

The following illustrations show some changes in the electrocardiogram which we believe were influenced by the intravenous administration of procaine hydrochloride. Figure 1 shows a reversion from an impure flutter to a normal sinus rhythm and a normal rate in case 1. Figure 2, with tracings taken before and after the second infusion, shows a great change in the deviation of the S-T segment in case 2. Figure 3 exhibits a correction of a first degree auriculoventricular block, a rather pronounced modification of the S-T segment, and slowing of the rate in case 7.

It is readily admitted that these cases show the greatest and most favorable electrocardiographic changes. Some tracings were influenced little by the medication. In others the changes following the administration of procaine were only transient. The greatest effect on the electrocardiogram seemed to be in the correction of abnormal rhythms, and secondarily the procaine appeared to modify the degree of deviation of the S-T segment.

Associated diseases and complications of the infarction or treatment were rather frequent in this series of cases:

Congestive failure	6
Pneumonia	3
Diabetes mellitus	2
Severe shock	2
Fever of undetermined origin	1
Urticaria due to penicillin	1
Paralytic ileus	1
Psychosis	1
Hypotension due to procaine	1

In some cases more than one complication developed, as shown in table 1.

There were 4 deaths in our series of 18 cases, or a 22 per cent mortality rate. Two occurred suddenly on the thirteenth and fifteenth days at a time when it appeared that the patients were well on the way to recovery. The other 2 occurred early in the illness. Only 1 patient expired during the first three days of the administration of procaine. In case 15, the patient received the last procaine infusion 18 hours prior to death. This is not a particularly low mortality figure compared to that for some series reported. A recent report by Wooten and Keyser,[17] however, on a study of 455 patients suffering from acute myocardial infarction stated: (1) the mortality rate for the entire group was 39.5 per cent, (2) the mortality rate for patients suffering from the first attack who did not receive anticoagulant therapy was 43 per cent, and (3) the mortality rate for patients suffering from more than one attack who did not receive anticoagulant therapy was 81.6 per cent.

Three of our patients who died were in shock on admission, and the other had had two previous myocardial infarctions and was in congestive failure on admission. The following are brief summaries of the case histories:

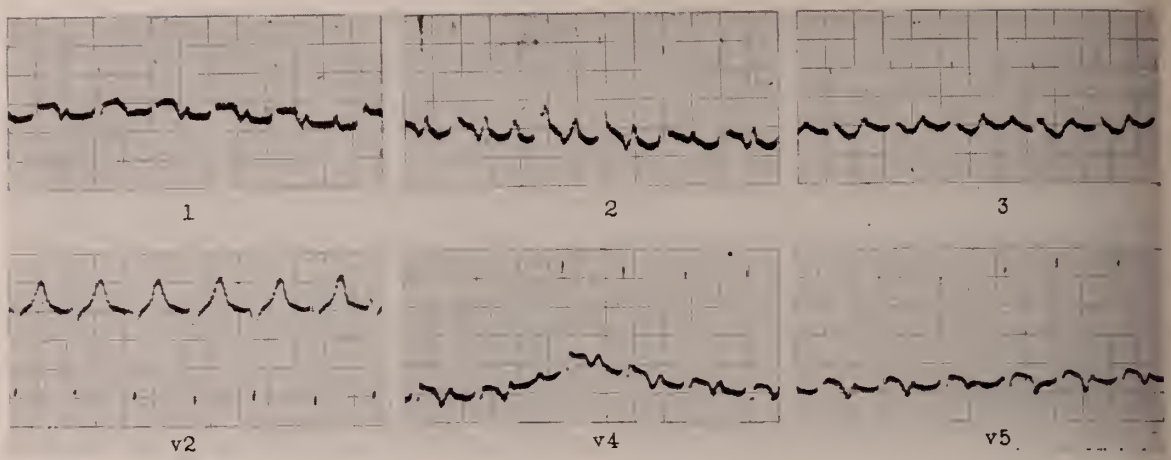


Fig. 1A, Case 1. — Before first infusion. Auricular rate 290; ventricular rate 130; QRS 0.05 sec. Impure flutter with 2:1 and occasional 3:1 block.

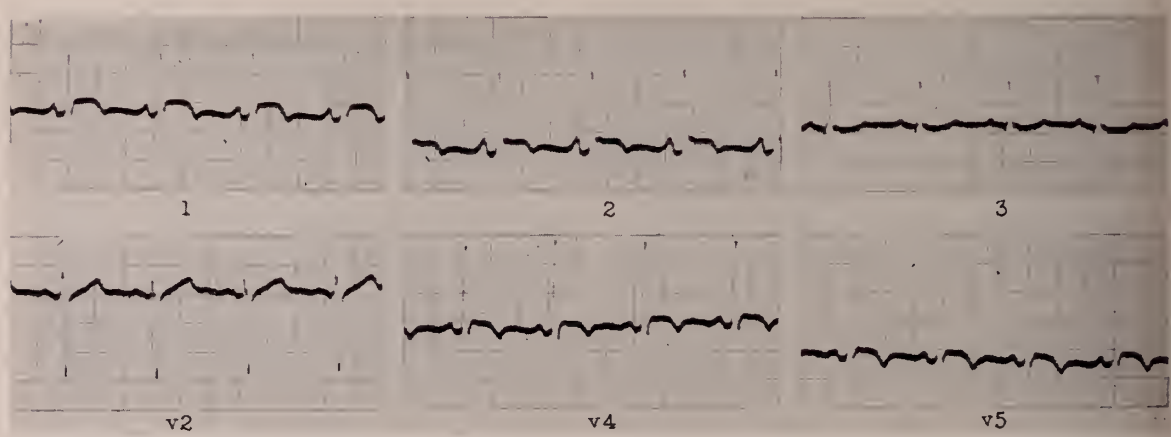


Fig. 1B, Case 1. — After first infusion. Auricular rate 94; ventricular rate 94; P-R interval 0.14 sec.; QRS 0.05 sec. Reversion to a normal sinus rhythm at a normal rate. No significant change in the S-T segment elevations.

Report of Cases

Case 2. — A 72 year old white man, who had suffered acute onset of substernal pain radiating down the left arm and shortness of breath, had collapsed on the street. When he was seen in the emergency room no radial pulse was felt, the heart sounds were weak, and only a few beats were heard between 80 and 60 mm. of mercury on the sphygmomanometer. The patient was dyspneic and cyanotic. He was treated only with intravenous procaine in the emergency room. Following its administration the pain and shortness of breath disappeared, the pulse increased from 50 to 84, and the blood pressure rose to 170 mm. of mercury systolic and 100 diastolic. Electrocardiograms showed a posterior infarction and auricular fibrillation. On the fifth day pneumonia developed in the upper lobe of the right lung. There was good response to penicillin, and he again felt well. On the afternoon of the twelfth day, however, the respirations and pulse became rapid, the blood pressure fell, he became faint and expired during the night.

Case 10. — A 54 year old Negro man was brought to the emergency room in severe shock with unobtainable blood pressure. The electrocardiogram showed posterior myocardial infarction with pronounced deviation of the S-T segment. A nodal rhythm was present. Norepinephrine was added to the procaine solution, and although the patient seemed slightly better for a short period, his condition remained critical, and he expired in seven hours.

Case 15. — A 61 year old white man had had two myocardial infarctions two and a half years previously and pronounced hypertension for 12 to 15 years. He had been taking digitalis daily and mercurial injections weekly in the past year. He was brought to the emergency room with severe substernal pain, shortness of breath, and severe diaphoresis; the heart sounds were faint and obscured by the pulmonary edema present. The patient also received digitalis, repeated morphine, oxygen, mercurial diuretics, and quinidine, in addition to the procaine. He remained in pulmonary edema in a critical condition and expired on the fourth day.

Case 18. — A 39 year old Negro man was admitted with substernal pain, dyspnea and severe shock. He was treated with morphine, oxygen, and norepinephrine in addition to the procaine and made a good response. After being asymptomatic for several days, he got up to go to the bathroom on the fifteenth day and again severe pain developed in the chest. He expired in a few hours.

the drug sometimes producing nausea, vomiting, dizziness, metallic taste in the mouth, trembling, apprehension, excitability, tachycardia, dermatitis, a drop in the blood pressure, collapse, convulsions, and death. The cutaneous sensitivity is rather

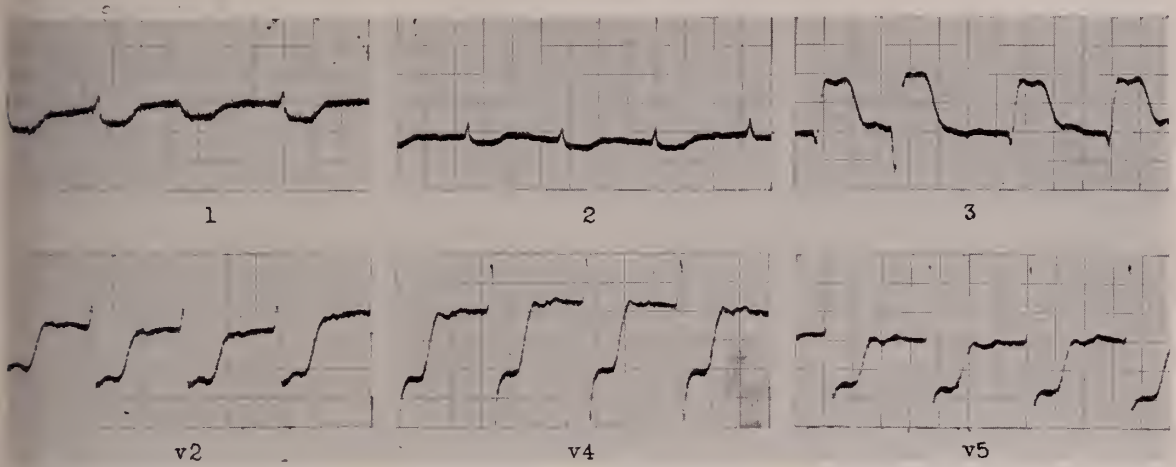


Fig. 2A, Case 2. — Before second infusion. Auricular rate 88; ventricular rate 88; P-R interval 0.28 sec.; QRS 0.08 sec. Acute posterior myocardial infarction with exaggerated S-T elevation in lead 3 and depression leads 1, 2, v2, v4, v5. Occasional premature auricular and ventricular contractions.

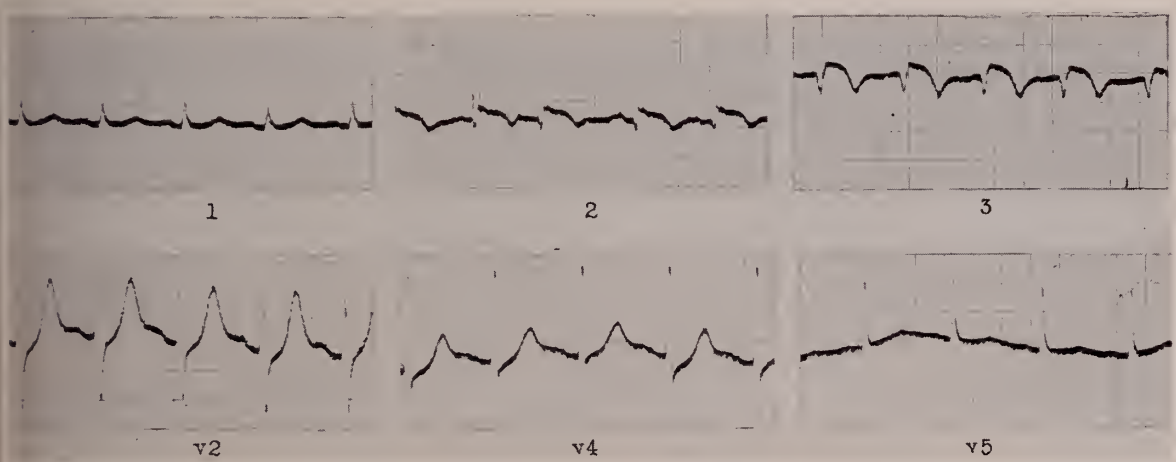


Fig. 2B, Case 2. — After second infusion. Auricular rate 98; ventricular rate 98; P-R interval 0.18 sec.; QRS 0.08 sec. Marked modification of the S-T segments and shortening of the P-R interval in spite of slight increase in the pulse.

Comment

None of these deaths occurred in uncomplicated "routine" types of myocardial infarction, and it would not be unexpected for any or all of these patients to die on any routine treatment. There were no adverse reactions from the procaine contributing to these deaths.

Some patients reportedly have an idiosyncracy of considerable degree to procaine hydrochloride, common and may be seen on the hands of dentists who handle this drug frequently.

To prevent the possibility of severe toxic reactions in administering procaine hydrochloride intravenously for any cause, the rate of flow should not exceed the procaine unit, which is calculated as 4 mg. per kilogram of body weight in 20 minutes.[18] As a further precaution, intradermal tests are sometimes used; barbiturates may be admin-

Table 1. — Summary of Series of Eighteen Cases of Acute Myocardial Infarction with Intravenous Procaine Therapy

Case	Race Sex Age	Hours Before Treatment	Pulse Before Procaine	Pulse After Procaine	Blood Pressure Before Procaine	Blood Pressure After Procaine	Electrocardiogram on Admission	Complications	Relief of Pain	Digitalis on Admission	Congestive Failure in Hospital	Past Infarct	Days in Hospital
1	N F 52	1	120	80	76/56	130/90	Anterior infarct, impure flutter	Congestive failure, small pulmonary infarct with Dicumarol 18th to 28th days. Fever in 3rd and 5th weeks	Yes	No	34th day	0	45
2	W M 78	1	50	84	80/60	170/100	Posterior infarct	Congestive failure, pneumonia, right upper lobe, on 5th day. Expired suddenly on 13th day	Yes	No	12th day	1	13
3	W F 48	1	80	70	140/85	170/100	Anterior infarct	Thrombophlebitis, right leg 13th day. Started on Dicumarol, penicillin urticaria	No	No	No	0	32
4	W M 72	2	80	80	180/80	154/88	Posterior infarct	Paralytic ileus 5th day. Treated by suction. Bronchopneumonia 7th day	Temporary	No	No	0	15
5	W F 67	8	100	74	140/90	160/100	Posterior infarct	Diabetes	No	No	No	0	25
6	W M 62	4	60	80	150/88	140/80	Anterior infarct	Diabetes	Yes	No	No	2	26
7	W M 52	7	72	80	120/70	104/72	Posterior infarct, first degree AV block	None	Temporary	No	No	0	26
8	W M 48	½	100	100	90/60	110/90	Posterior infarct	None	No	No	No	0	13
9	W M 55	3	86	92	190/120	186/120	Anterior infarct	None	Partial	No	No	0	18
10	N M 54	1	50	60	0/0	60/?	Posterior infarct, nodal rhythm	Severe shock. Expired after 7 hours	No	No	No	1	
11	W M 51	12	80	90	110/80	94/86	Anterior infarct, right bundle-branch block	Congestive failure, bronchopneumonia	Undetermined	No	5th day	0	18
12	W F 66	3	64	60	178/106	176/84	Posterior infarct	None	Undetermined	Yes	No	1	26
13	W F 56	8	108	104	120/80	120/80	Anterior infarct	Congestive failure	No	Yes	15th day	0	25
14	W F 78	13	100	88	130/110	140/88	Anterior infarct	Congestive failure	Undetermined	No	4th day	0	37
15	W M 61	2	100	110	218/104	150/90	Anterior infarct, old posterior infarct	Congestive failure. Expired on 4th day	Undetermined	Yes	On admission	2	4
16	N F 63	12	120	120	118/80	118/80	Anterior lateral infarct	Great cardiac enlargement. Blood pressure dropped to 90/60 with second infusion. Corrected when rate of flow slowed	Partial. No relief from morphine	Yes	No	1	30
17	W M 84	16	80	86	140/90	100/80	Anterior infarct	Jumped out window 9th day. Transferred to psychiatric ward 13th day. Discharged 4 weeks later	Yes	No	No	0	13
18	N M 39	2	104	120	0/0	90/60	Right bundle-branch block, anterior infarct	Severe shock, but recovered. On 15th day got up to bathroom, severe pain, collapse, expired	Undetermined	No	No	0	15

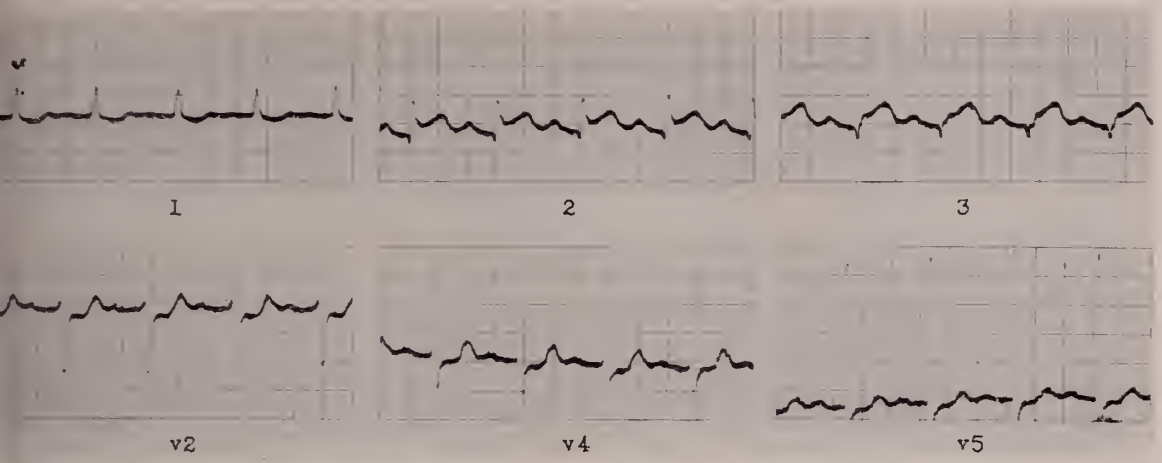


Fig. 3A, Case 7. — Before first infusion. Aurieular rate 102; ventrieular rate 102; P-R interval 0.23 sec; QRS 0.07 sec. Aeute posterior infarction with prolonged P-R interval. S-T segment elevated in leads 2 and 3 and depressed in precordial leads.

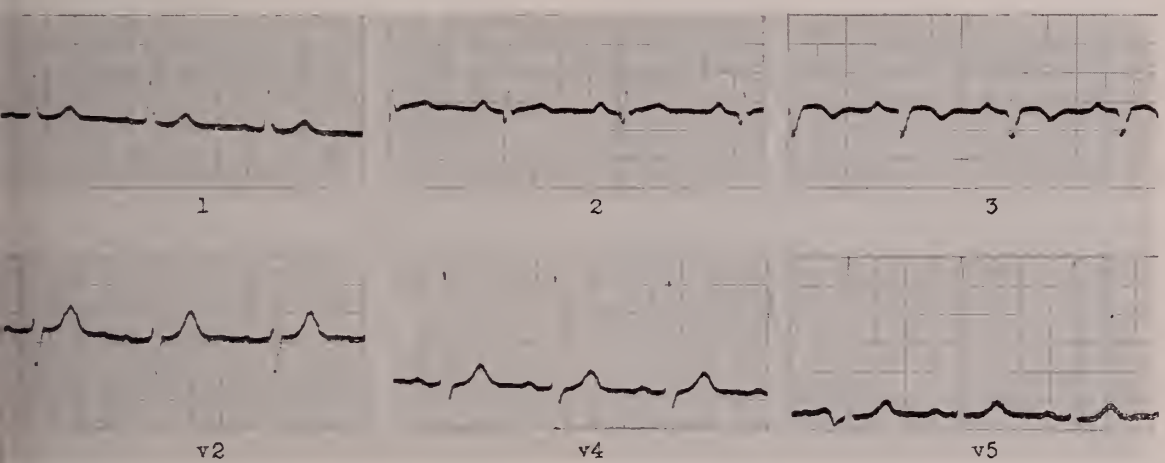


Fig. 3B, Case 7. — After first infusion. Aurieular rate 75; ventricular rate 75; P-R interval 0.20 sec.; QRS 0.07 sec. Slowing of rate, decreased P-R interval, and return toward normal of the S-T segment deviations.

stered beforehand, or a syringe containing a barbiturate should be ready for intravenous injection in case of a serious toxic effect. It is also claimed that the addition of ascorbic acid decreases the toxicity of intravenous procaine. In none of our patients did we notice clinically any serious side effects, except for the fall of blood pressure in case 16 already mentioned, which returned to normal on slowing the rate of infusion. It is true that clinically some minor reactions may have been obscured by the serious primary disease, but the effect of the drug on the cardiac rhythm, cardiac rate, pain, and general well-being of these patients more than offset any minor reactions that occurred.

We realize that our series of cases is small. In our observation of these cases, however, and other related conditions not here recorded, such as angina pectoris without infarction and superventricular and ventricular tachycardias, we are convinced that the intravenous administration of procaine hydrochloride is not only a procedure of relatively little danger, but is a valuable addition to the treatment of acute myocardial infarction. Studies of larger groups of patients with controls will have to be made to substantiate our impressions. Swerdlow[19] investigated the rectal installation of procaine solution and found that adequate absorption into the circulating blood may

be obtained. It is possible that further investigation of procaine in myocardial infarction will reveal that the most suitable administration is a constant rectal drip over a period of several days.

Summary

Intravenous procaine hydrochloride has been used widely in many clinical conditions without demonstrable damage to any organs in humans.

Experimental studies of the physiologic and electrocardiographic effects of intravenous procaine on the heart are reviewed.

A series of 18 consecutive cases of acute myocardial infarction is reported in which 500 cc. of a 0.2 per cent solution of procaine hydrochloride was administered intravenously every 12 hours for three days. Under this therapy the pulse rate, when either rapid or slow, tended to return toward normal. Also, there was no adverse effect on the blood pressure in the acute phase.

The greatest change in the electrocardiograms was a correction of abnormal rhythms and a modification of the deviation of the S-T segment.

There was a wide variation in the relief of anginal pain. Procaine should not be relied on as a substitute for narcotics. The patients subjectively felt a sense of relaxation and improvement, especially with the first infusion of procaine.

The only side reaction to the drug was a moderate fall of blood pressure on one infusion in 1 patient, which was corrected by slowing the rate of flow.

There were 4 deaths in our series, the mortality rate being 22 per cent, but only 1 occurred during the first three days when procaine was being administered.

The administration of intravenous procaine in early acute myocardial infarction is a relatively safe procedure and appears to be a valuable addition to the treatment of this condition. A study of larger groups of cases will have to be made to substantiate our impressions.

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THE EIGHTIETH ANNUAL CONVENTION

of the

FLORIDA MEDICAL ASSOCIATION

HOLLYWOOD BEACH HOTEL APRIL 25-28, 1954

The Management of the Asthmatic Patient

Maurice Kovnat, M.D.
MIAMI BEACH

Medicine is not a static science. New discoveries and advances bring new impressions and changing methodology. Review and reappraisal are often necessary from time to time to determine if we are on a rational path in the management of a particular disease state. The story of asthma may be divided into the three quarters of the present century. In the first quarter many able investigators[1-4] contributed greatly to the knowledge of immunity and hypersensitivity. The second quarter saw the application of these principles to the control of the hypersensitive state by hyposensitization[5-7] and the addition of practical methods of relieving the asthmatic seizure by the use of sympathomimetic and antihistaminic drugs, and the development of aerosol therapy. The present third quarter was ushered in by the development of additional mechanical aids for the relief of the hypoxia and the discovery of the corticosterones.

In 1951 Reiss, Baum and Kovnat[8] reported experiences with these drugs in various pulmonary conditions. It was our opinion at that time that cortisone and corticotropin were valuable additions to the physician's armamentarium for the treatment of the patient with asthma. In the two years that have elapsed further evidence has accumulated testifying to their effectiveness, with the result that the pendulum has taken a wide swing in their favor. As a matter of fact, the emphasis has been so pronounced that it threatens to disrupt the orderly and established process of management of the asthmatic patient. It would, therefore, be profitable to review the entire problem in an attempt to establish the proper place of the many recent advances in the over-all picture of asthma control. A brief review of the fundamentals involved will help achieve a common ground of understanding and definition.

Hypersensitivity

All organisms, unicellular or multicellular, are endowed with the characteristics of sensitivity, the ability to react to a foreign or invading substance. It is their mode of defense in an unfriendly environment. Phagocytosis is this expression on a cellular level, the phagocytes destroying the invader by ingesting it, without any profound disturbance to themselves. In a minority of instances, however, certain specialized cells react to the invader in a different manner. Their cell globulin is converted into antibody globulin which has the ability to bind or neutralize the foreign agent or antigen on subsequent contact. Such cells or groups of cells are designated hypersensitive, and the reaction hypersensitivity. A product of this reaction is histamine, or histamine-like substances. It is the latter which is thought to induce the edema and smooth muscle contraction with the evolution of the clinical picture of asthma when it involves the cells of the bronchial structures.

The simple term of asthma should, therefore, suffice to denote the condition which is characterized by the clinical expression of hypersensitivity of the bronchial structures to a noxious agent which has the ability to excite the antigen-antibody reaction, whether that agent originates from a food protein, an inhalant, or a bacterial product. In essence, then, hypersensitivity is the predominating factor which determines whether one is dealing with asthma or with some other condition which, though clinically resembling it, is totally unrelated in the manner of its production, its course, or its management. We cannot, therefore, rightfully ascribe this term, even in hyphenated form, to a wheezing mechanism inducted by any other means, whether it be cardiac failure, endobronchial plugging by inflammatory exudate, foreign body or neoplastic growth. Such terms as asthmatic bronchitis, allergic bronchitis, nonallergic bronchitis and cardiac asthma are misnomers and should be avoided.

This reaction of hypersensitivity, so important for the proper diagnosis of asthma, has certain features which usually makes it readily recognizable. In some instances, however, its correct

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identification may be difficult. Heredity is an important characteristic, but the thread of inheritance may be hidden and not easily discernible. The presence of specific hypersensitivity in other structural areas in the same person is another characteristic, but this too may be difficult to uncover. Eosinophilic response is another, but its absence does not exclude the hypersensitive state, and its presence is found in many other conditions outside this category. Skin reactivity to specific antigens is still another, but positive reactors do not necessarily indicate clinical offenders, nor do negative results always mean blameless antigens. Despite these hindrances the combination of a careful history, a thorough physical examination, complete skin testing, close observation, and good clinical judgment will eventually disclose the characteristics of the hypersensitive state and thus lead to the true diagnosis of asthma.

Offending Allergens

Once such a diagnosis is established, the next step is the search for the offending antigen or antigens. This may be a relatively simple procedure, or it may be an extremely difficult one. A concise and detailed history is the first requisite. Complete and careful skin testing is another, avoiding overreading of doubtful reactions, a common error which has done much to discredit this valuable procedure. If foods are suspected, elimination diets are helpful in uncovering nonreacting antigens. Infectious agents are sources of allergenic proteins, and because some patients harbor such atopens in various foci, sinuses, throat and bronchi, the hypersensitive reaction they provoke is often labeled intrinsic asthma.

Hyposensitization

Following these two procedures, the diagnosis of the hypersensitive state and the uncovering of the offending allergen, the next step for controlling the asthmatic state concerns itself with the interruption of the antigen antibody reaction, the clinical manifestations of which are responsible for the asthmatic attack. In some instances this may be easily accomplished by removing the known antigen from the patient's environment, or vice versa. When removal is impossible, the harmful effects of antigen host reaction may often be controlled by the process of immunizing or desensitizing the host's cells by the introduction of the offending atopen in gradually increasing doses over an extended period of time, usually years in duration. By this means the blocking antibody, normally present in most persons, is increased in titer. These blocking antibodies bind the offending protein before it can reach and engage the cell antibody globulin, thus preventing the liberation of histamine-like substances which are responsible for the local cellular reactions and clinical manifestations of asthma.

Treatment

These three basic principles for control of the asthmatic state, the recognition of hypersensitivity, the detection of the offending antigen, and the restraint of its harmful effects by elimination or hyposensitization have unfortunately been neglected of late. Instead, the short cut of symptomatic treatment has assumed the major role in the treatment of asthma, and sometimes the only role. The recent introduction of the corticosterones has furthered this unscientific approach.

There is no denying that the treatment of the asthmatic seizure plays an important part in the over-all problem, but it must be based on sound principles, and carried out in an orderly fashion. The management of an asthmatic attack may be considered under several subdivisions, that of the first or initial attack, the recurrent attack, the low grade form or chronic asthma, and the persistent attack of severe asthma or status asthmaticus.

The first visitation of this illness usually presents no great difficulty for its relief. Simple measures, as a rule, produce prompt subsidence of the seizure. Three to 5 minims of subcutaneous adrenalin may be all that is necessary. Occasionally, one or more doses of intravenous aminophylline may be required. Unless the allergen initiating the attack fails to reappear, it is unlikely that the seizures will soon fail to repeat themselves. In such event, one is no longer concerned solely with the asthmatic attack, but must consider the broader aspects of the asthmatic state. It, therefore, behooves the attending physician to make a thorough and prompt investigation according to the principles laid down earlier in this discussion. While carrying on this program, and until the hoped for complete control of the entire syndrome is accomplished, the patient must be under constant medical observation in order to ward off and relieve the expectant recurring seizures.

It is in these recurring and persistent attacks that good clinical judgment is most important. Early hospitalization is a wise procedure. It has the distinct advantage of removing the patient from what may be a harmful environment, both

from the allergenic and psychogenic aspects, of permitting the use and better regulation of indicated drugs and modalities not otherwise easily obtainable, and the close observation of the patient by competent personnel, thus saving the physician many arduous home visits.

The wise and judicious use of drugs is most important. Two conditions constantly plague the asthmatic patient in this respect, drug hypersensitivity and drug fastness, the one further aggravating the asthmatic syndrome, the other delaying its termination. What may be helpful, therefore, for one person may be useless or even distinctly harmful for another. In general, all drugs administered to an asthmatic patient must be given with utmost caution. It is a good rule to inquire at the outset what drugs the patient may be intolerant to, what drugs were previously employed, and with what results. Any new drug should be used cautiously and on a trial basis. The common error of overtreatment must be avoided. Not infrequently a patient will be ingesting more than a dozen drugs in one day. Included among them may be many with toxic or undesirable side effects, or even sensitization potentialities. Listing them would fill a whole page, but the most common are one or more antihistaminics, phenobarbital, calcium gluconate, potassium arsenite, Demerol, ammonium chloride, atropine sulfate, potassium iodide, ephedrine sulfate, Isuprel, penicillin, aureomycin and aminophylline. The removal of some or all of these drugs may often bring an end, not only to the severe and unpleasant side reactions, but also to the asthmatic seizure.

Under ideal hospital conditions, preferably in an air-conditioned allergen-free room, a minimum of drugs may suffice to control the seizure. In some instances, the change of environment alone may be all that is necessary. If the bronchospasm persists, short periods of aerosol therapy with simple bronchodilators, such as Vaponephrin or Isuprel, are often highly effective. Wetting agents, Zephiran chloride in 1:1,000 solution or propylene glycol in 50 per cent solution, may be added to liquify the thick inspissated secretion, the removal by expectoration contributing greatly to the eventual relief of the seizure. Intravenous aminophylline at four to six hour intervals will aid in maintaining the bronchodilator effects. Relief of the hypoxia will usually follow these measures, but additional short periods of oxygen administration may be necessary. The recently developed apparatus for delivering oxygen by intermittent positive pressure, by Bennett and Mine Resuscitation people, is an efficient method of administering both oxygen and aerosol medication.[9] The physician, however, must be careful to avoid the harmful and often dangerous effects of sudden excessive oxygen uptake in the hypoxic patient who has accustomed himself to maintain his respiratory gas exchange via the aortic and carotid reflex mechanism. The elimination of the latter by the increased oxygen saturation before the medullary respiratory center has had a chance to assume control produces a period of apnea which may result in delirium, coma and sometimes death. Increasing ventilation during this period, either voluntarily or by artificial mechanical measures, is one means of avoiding such catastrophies. Administering oxygen at periodic intervals instead of continuously is another.

Both physician and patient are often unduly concerned over the restlessness and loss of sleep during the severe attacks of asthma. Both go to extremes in the use of sedatives and narcotics to overcome these complaints. Sedation and relaxation are necessary, but should not be attained at the expense of an aggravated asthmatic syndrome with its increased hypoxia. It is better to have a restless patient who is blowing off carbon dioxide than to have one who is quietly asleep and accumulating it in his tissues. Physicians have all learned the lesson of morphine, the specific for asthma in earlier days, which terminated more cases than any other drug. Today Demerol has replaced morphine, and yet it is just as objectionable. Chloral hydrate and paraldehyde are preferable agents. No sedative or hypnotic should be used too frequently nor for any prolonged period. If attention is concentrated on relieving the bronchospasm and bronchial edema and secretion, with resulting improvement in oxygen uptake, the restlessness and insomnia will soon disappear.

If the attack is unrelieved by the measures mentioned and tends to increase in severity, it may be considered to have progressed to status asthmaticus. Here a reappraisal of the entire situation becomes imperative. If the patient is not already hospitalized, he should be immediately. Thought should be given to the uncovering of some undisclosed allergen previously overlooked, or to the development of a new hypersensitivity. The possible presence of a bacterial allergen should be carefully considered, the sinobronchitic tract being the most likely focus. In such event a course of antibiotics may help to

terminate an attack. A short course of Chloromycetin has been helpful in my hands.

The prolonged persistence of a severe asthmatic state compels attention to the general care of the patient, particularly in regard to the dietary, electrolyte and fluid balance. When the offending allergen is not immediately evident, it is a good policy to restrict food intake to the nonallergic or hypoallergic group, and in small quantities, in the hope that any provoking atopens will thereby be restricted or removed. When cardiac function is embarrassed as a result of pre-existing disease or strain on the right side of the heart, supportive cardiac therapy may be necessary and fluid and sodium intake curtailed. Otherwise electrolyte balance should be maintained and fluid intake encouraged to relieve the general dehydration and aid in the elimination of the sticky mucoid bronchial secretion. Occasionally, bronchoscopic drainage may be necessary to accomplish this purpose.

In the majority of cases of status asthmaticus there will be response to the regimen outlined. In some instances, however, the patient will have become resistant to the usual antiasthmatic remedies, the severe and persistent seizure will show no signs of abating, and his general condition will show evidence of deterioration. Then, and then only, the physician should resort to the use of cortisone or corticotropin. The intravenous use of ACTH is preferred, 10 mg. in 1,000 cc. of Ringer's solution being given over a period of eight hours and maintained at this rate for 24 to 48 hours. An amelioration of most of the symptoms may be expected at this time and with it a reversal of the drug fastness previously present. The addition of aminophylline and small doses of adrenalin will maintain the improvement as the dose of corticotropin is gradually reduced and its mode of administration transferred to the intramuscular route with the depository form. As the optimal improvement is attained, the drug should be slowly and gradually reduced to its effective minimum dose and finally entirely discontinued. Prolonged reliance upon it is unwise. Besides the potential dangers with such use, drug fastness here too will eventually develop, with annoying rebound symptoms upon their withdrawal. During the period of remission it is a good plan to review once again the entire problem and determine the course of action that would be most likely to prevent a recurrence of the previous unhappy episode.

The last group of patients to be considered may be classified as those with chronic asthma. They are usually persons with multiple hypersensitivities who have obtained maximal benefits by the routine measures of hyposensitization, dietary care and environmental changes, yet are still suffering with a certain degree of bronchospasm and reduced pulmonary function. By the judicious use and interchange of a few drugs and the aid of the ever present hand nebulizer, they have learned to accustom themselves to the handicaps of a low grade form of their affliction, experiencing intervals of fair remission and periods of troublesome relapses. When the condition deteriorates and they cannot obtain relief with self care, they seek the aid of a physician. Such patients have generally run the gamut of extensive investigation and therapy, both medical and surgical. The temptation to resort to cortisone or corticotropin is great, but should be resisted to the utmost for their use on a long term basis for relief of chronic asthma only leads to the proverbial tail-holding bear act.

A better plan is to re-evaluate the entire problem. A period of hospitalization is advisable. Often new facts can be uncovered that may contribute valuable information to the proper management of the condition on a sound and rational basis. Troublesome complications such as bronchial infection, pulmonary fibrosis, emphysema, or bullous formation may have developed that require particular attention. Some significant psychogenic factor may be the trigger mechanism that is operating to keep the hypersensitive patient in constant bronchospastic state. The alert attending physician, whether he be allergist, chest specialist, or family physician, can usually uncover such influences and help to overcome their harmful effects by a frank discussion of the conflicts pressing upon the patient.

The advent of a favorable result does not mean that the problem is permanently or completely solved. The asthmatic patient has a specific inherited weakness which is liable to rapid and sudden development. Constant medical supervision and treatment are necessary if the frequency, duration, and severity of the attacks are to be reduced, the complications avoided or minimized, and the entire asthmatic state placed under control.

Summary

The many recent advances for the control of the asthmatic syndrome have prompted a review

of the condition in an effort to evaluate their proper place in the over-all management of the problem. An orderly plan for dealing with both the asthmatic state and the asthmatic seizure is presented. For the former, three principles must be followed: the establishment of a hypersensitive state, the uncovering of offending allergens, and their removal or hyposensitization. For the latter, there must be a safe and sane use of indicated drugs for relief of the bronchospasm and bronchial edema and secretion, with such other measures as may be helpful in relieving the particular type of attack that the patient may be suffering from, the initial mild seizure, the severe recurring attack, the status asthmaticus or the chronic asthmatic form. In each case, a rational, well laid plan must be carefully followed.

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Screwworm Infestation in Humans

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The output of literature on the subject of screwworm (Cochliomyia americana) infestation in humans in the past 20 years has been almost nil. A report on the subject, therefore, may be of interest to new doctors in the state.

The state of Florida is fast becoming a major cattle-raising country, and infestation of screwworm in man is no longer a new parasitic disease. Since World War I Florida has become the home not only of people from all over the world but also of foreign animals, birds, exotic flowers, trees and reptiles along with parasites and germs from everywhere brought in by these new hosts.

Evidently the screwworm arrived on cattle from the Southwest United States which were sent into Florida by the United States Department of Agriculture following the dust storms of 1933. The grazing lands in Texas, Oklahoma and Arizona were destroyed by the drought, and the cattle were starving. Florida had just begun growing new grasses for pasture lands at the time these cattle were transported to Florida for fattening. Within a couple of years this new parasite was widely distributed among the native cattle in this virgin territory, and almost immediately humans became infested.

Read before the staff of the Munroe Memorial Hospital, Ocala, March 1952.

Some of the first cases of this parasitic infestation in man were reported by Dr. H. Marshall Taylor[1] of Jacksonville. In many cases at that time death ensued from meningitis, hemorrhage and complications. Aubertin and Buxton[2] reported 179 cases with 15 deaths. Yount and Sudler[3] reported 23 deaths in 100 cases.

In a study of blow flies, Cushing and Patton[4] concluded that Cochliomyia americana is the true myiasis-producing screwworm fly of the Americas. This fly is a shiny bluish green blow fly, distinguished from the ordinary bluebottle fly by three longitudinal black stripes symmetrically arranged on the thorax or scutum. The head is short, red or yellow in color, and closely attached to the body. Stiff black hairs cover the body, which is metallic in appearance. This species of fly is small, varying in length from 10 to 13 mm. (fig. 1). The female lays at one time from 10 to 400 oblong yellowish eggs, depositing them on the edges of the wounds and in the body cavities. The eggs are cemented together in shingle-like masses rather than in haphazard fashion as are those of other blow flies. In from six to 21 hours the eggs hatch (fig. 1).

The tiny larvae, known as screwworms, are described as whitish footless grubs that are rather

slender and quite active; they feed in clusters and burrow into live flesh until soon a pocket or cavity is formed. When these worms reach maturity in from three to 10 days, they attain a length of 13 to 19 mm. and have 12 segments with a belt of minute spines or bristles around each one. They somewhat resemble a screw as the body tapers from the large posterior end to almost a point at the head. Embedded in the living flesh, the head is provided with two hornlike mouth hooks capable of tearing living tissues and causing them to bleed. The posterior end remains uppermost for on it are situated the spiracles or breathing orifices (fig. 1).

On reaching maturity the screwworms drop from the host to the ground, where they burrow into the soil, burying themselves while the skin hardens as they pass through the pupal stage to develop into the adult fly. The pupae are brown elongated ovals in shape and about 10 mm. in length. Emerging in seven to 14 days, the adult flies are ready to mate and lay eggs after an additional period of from five to 10 days. Thus the average life cycle is approximately 24 days, and in consequence a number of generations may be bred in a single season (fig. 1).

In man the common site of infestation is usually the nose. From here the larvae eventually spread to contiguous areas of the ethmoid sinuses, turbinates, soft palate, septum, maxillary antrums, frontal sinuses and sphenoid sinuses, especially if they are necrotic. They may also extend to the tonsils and pharynx or even drop down into the lungs and esophagus. When they enter a lung, naturally they act as any foreign body with its complications and sequelae. In some cases the parasites have been found in the eye and lacrimal duct. Even the brain and bone have been invaded. A primary site may be the external auditory canal if there is pus or discharge attracting the female fly, just as maggots of the blow fly are encountered in discharging ears in other parts of the country.

The smell of blood seems to attract the fly, but probably an important factor is the fetid odor of decaying flesh in a live warm-blooded animal. Any open wound, however, may attract her. Some authors have reported the fly attacking normal tissue. The Year Book on Insects of the United States Department of Agriculture for 1952[5] states that before an animal can become infested with screwworms, some break must occur in its body surface. Very cold weather may cut down on the number of infestations.

Within 24 hours after they are deposited in a favorable environment the eggs hatch out. The young parasites then penetrate deeper into the surrounding tissue by making use of the spiracles and belts of spines which bore into the tissue like a screw — hence the name.

Symptoms are rather unimportant in this type of case since the signs are self evident. After having seen a few cases I find it hard to conceive of anyone not being aware of the presence of squirming screwworms in the nose. Difficult breathing, headache, a tickling sensation and bloody discharge are characteristic symptoms. There may be a temperature of 104 F., probably from concurrent infection, and later edema and swelling occur around the involved area. The actual larvae may be seen on the bed clothes or floor. The larvae vary in number from a few to several hundred, depending on the number of infestations and conditions.

The diagnosis is obvious as one looks into the infested wound and sees the larvae standing on end with head or small end down and all of them trying to get to a different place at once. It really is a sight.

Complications result from invasion of the sinuses, eyes, ears, nose, throat, lungs and brain, causing hemorrhage or meningitis. A fatal termination was common in the past, but nowadays, with better information about the screwworm among farmers and cattlemen, better facilities for getting to a hospital, and better informed doctors, the death rate is much lower. In fact, I do not know of a death in recent years.

Treatment

The treatment for screwworms primarily is the removal of the larvae wherever found. Since the nasal cavity is the predominant site of infestation, I believe it is best to send the patient to the hospital under the care of a capable ear, nose, and throat specialist, since he should be more familiar with the anatomy of the sinuses and adjacent structures.

In extensive cases it is best to put the patient to sleep with a general anesthetic. The posterior nasopharynx is blocked off with cotton or gauze to prevent any larvae getting down the pharynx. Then with a good light and nasal speculum, liquid ether may be poured into the nasal cavity. This will probably kill most larvae. Then with Coffin's ethmoid forceps, the larvae may be picked out in-

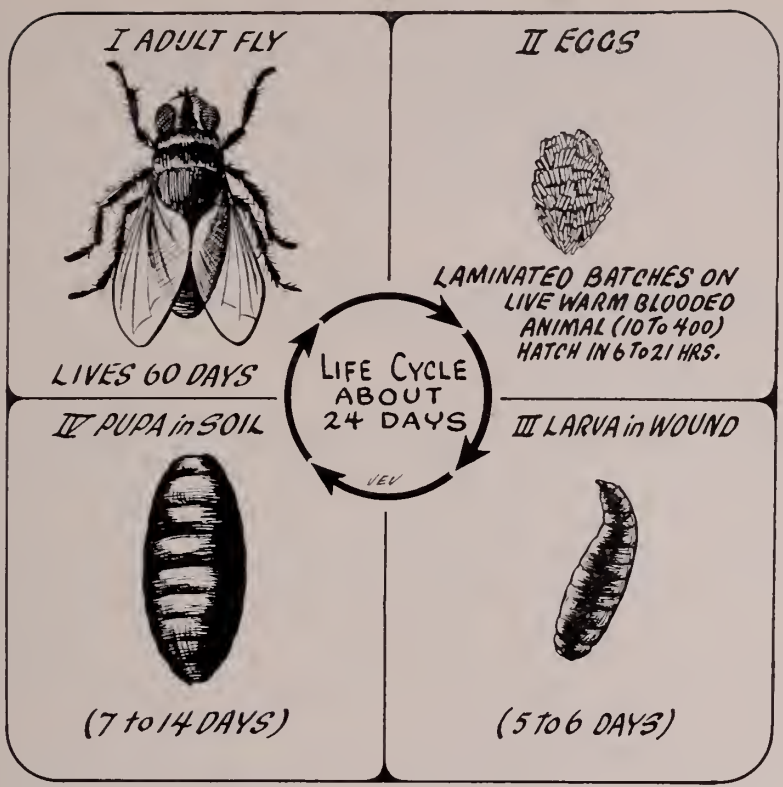


Figure 1

dividually. A complete ethmoid exenteration may be necessary, and if the larvae are in the antrums, a radical antrum operation (Caldwell-Luc) may be necessary.

In a recent case in which more than a hundred larvae were removed, a good ethmoid exenteration had already been done by the larvae. The patient seemed to suffer no ill effects from her experience and was, in fact, better off afterward, for she had been suffering for years from a chronic polypoid sinusitis and now the whole necrotic area had been thoroughly cleaned out by the larvae.

This case brings to mind the maggot treatment of osteomyelitis and other suppurative infections, as reported by Baer of Johns Hopkins University.[6] This method of treatment won the approval of the Council on Pharmacy and Chemistry of the American Medical Association. I, however, would not recommend the use of the screwworm larvae.

After every larva has been removed, the wound is irrigated with warm saline and left free of packing unless there is excessive bleeding. In other words, treat the condition as in any other intranasal sinus operation.

Antibiotics or sulfonamides should be given and other general measures used as indicated, such as opiates, laxatives, diet and vitamins, including advice.

Naturally the best treatment is prophylaxis. Persons who have a chronic sinusitis of long standing or open sores and live in the country where the screwworm is known to exist should not doze out in the yard with orifices open. It only takes a few seconds for a female screwworm fly to deposit her load of eggs in a fetid cavity.

This pest has a more devastating effect on both domestic and wild animals than any other insects; uncontrolled, its larvae are capable of wiping out entire herds of cattle, hogs, sheep, goats and deer. They attack any warm-blooded animal, for they are true parasites that take up their abode only in the living flesh of such an animal.[7]

Summary

Screwworm infestation in man is at times a medical problem in Florida. A fatal termination can be avoided if the condition is recognized early and treated effectively.

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ABSTRACTS OF MEDICAL ARTICLES

Therapy of the Failing Heart. By G. F. Schmitt. Postgrad. Med. 13:344-353 (April) 1953.

After presenting basic principles, the author discusses the value of and indications for oxygen therapy together with the gage, catheters, masks and other details of its administration. A table presents a comparison of the rates of flow and concentrations in an average-sized man with the use of various devices.

A low sodium diet is given and discussed. Cardiotonic principles and diuretics are listed with details as to administration and other information. Relations of glycosides, sources of cardiotonic principles and the various aspects of digitalizations are outlined in some detail.

Specific Transfusion Therapy. By Donald W. Smith, M.D., John Elliott, Sc.D., and James J. Griffitts, M.D. Surgery 33:525-536 (April) 1953.

Observing that the routine use of whole blood for transfusion without consideration of the specific indication for its components, cells and plasma is not rational therapy, the authors urge a more specific use of blood transfusions. They discuss the use of whole blood, cell suspension, and plasma, separately or in combinations, to meet the specific and quantitative needs. They also discuss the relative significance of the blood volume and body protein deficits in the chronically ill patient in relation to the indications and urgency of replacement requirements.

Outlined are the indications and advantages of the separate blood components for transfusion, and a method of quantitative replacement of these components is presented. Cell suspension and whole blood replacement in anemia is calculated by using the percentage deficit in the patient's blood estimated on a standard blood volume of 40 cc. per pound of body weight.

A method of continual quantitative plasma replacement in burn shock, based upon bedside hemoconcentration determinations by the copper sulfate method, is presented. The hemoconcentration is quantitatively corrected with the use of 40 cc. per pound of body weight as standard blood volume. This is repeated at intervals of one or two hours during the 48 to 72 hours of continuing plasmorrhage.

Vesical Neck Obstruction in Neurogenic Bladders. By Raymond J. Fitzpatrick, M.D., Louis M. Orr, M.D., and Joseph C. Hayward, M.D. South. M. J. 46:791-798 (Aug.) 1953.

A discussion of vesical neck obstruction in neurogenic bladders is presented. The authors believe that in many instances the term obstructing tissue is a misnomer and should be used with caution and only when truly indicated. They conclude that it is not the actual removal of obstructing tissue per se, especially in those cases in which the vesical neck is patulous, but rather the interruption of antagonistic nerve elements at the bladder neck or in the prostatic urethra directly by resection or secondarily as a result of penetration of the thermal coagulation that permits a return of vesical function. They advocate deep resection of the posterior vesical lip down into the muscular elements of the trigone in this region as well as resection down to the capsule in all directions.

Following a successful result attendant upon transurethral resection, they note that the patient must be followed for a long period of time, for febrile episodes can easily upset the balance obtained and urethral dilatations are a necessary part of the postoperative treatment in order to reduce resistance along the course of the urethra. They also re-emphasize the fact that in cases in which adequate transurethral resection has been per-

formed and failure of vesical function has followed, other factors such as spastic striated muscles of the pelvic floor may be the cause of continuing dysfunction, and that a direct approach upon the nerve elements themselves supplying these muscles by either pudendal neurectomy, rhizotomy or subarachnoid alcohol blocks, must become a part of the urologist's thinking in the rehabilitation of these patients. In cases in which large atonic bladders fail to respond, subtotal cystectomy may be indicated.

Infarct of the Testicle: Report of Three Cases. By G. Ashby Winstead. J. Urol. 9:830-835 (June) 1953.

Infarct of the testicle secondary to factors other than torsion is most uncommon except in the newborn. Three cases are reported in which infarct of the testicle was not due to torsion of the spermatic cord. It is noteworthy that in 2 of these cases the onset was essentially painless. Thorough studies failed to disclose the etiology. The literature is briefly reviewed, and the various aspects of the subject are discussed.

The Treatment of the Chronic Middle Ear, Including Anterior Myringotomy in Secretory Otitis Media and the Pathogenesis of Cholesteatoma. By Richard A. Bagby, M.D., and J. Brown Farrior, M.D. South. M. J. 46:712-718 (July) 1953.

In this presentation the authors seek to emphasize the old fashioned, reviewing and stressing the value of the long-taught method of cleansing and drying the chronic ear, and they mention a few specific indications for surgery and for conservative management.

They observe that cholesteatoma may be treated when the disease is accessible and that in its presence good hearing is a prime indication for early modified radical mastoidectomy to prevent deafness. They advance the theory that untreated otitis media with effusion may cause cholesteatoma.

In suspected cases of otitis media with effusion, they recommend wide anterior myringotomy with suction. Also, they advocate secondary myringotomy with aspiration if the hearing or drum has not returned to normal two or three weeks after all cases of acute otitis media. It is their opinion that more simple mastoidectomies should be performed. In chronic otitis media, operation is the exception. The time-tried measures of mechanical and chemical cleansing of the middle ear will diminish the discharge so that dry treatment with boric acid and Sulzberger powder will suffice in the majority of cases.

A Simple Method of Roentgen Pelvimetry. By Robert W. Curry, M.D. Am. J. Roentgenol. 69:638-646 (April) 1953.

Dr. Curry describes an original method for measurement of the transverse diameters of the pelvis. Not only is the roentgenographic technic simpler and more economical than in other methods described but all measurements can be taken directly from the wet film without resorting to calculations, charts, nomograms, or body measurements.

The theory of this method is that by using a target-film distance of 5 feet, the divergent distortion of the transverse diameters of the pelvis becomes relatively constant and the possible error in the measurement of the actual dimensions is so small that it is of no clinical importance and is no greater than is present in many other methods of pelvimetry. Although no special equipment is required, it is necessary to have roentgenographic equipment in which a 5 foot target-film distance can be obtained.

Methyl Cellulose in Ophthalmology. By Robert C. Welsh, M.D. South. M. J. 46:819-820 (Aug.) 1953.

The author reports his experience with methyl cellulose, a nonirritating, chemically inert colloid which has become increasingly popular since its introduction into ophthalmology in 1945. He finds that this colloid, if properly used, is an excellent viscid agent for combination with ophthalmic solutions of antibiotics, sulfonamides and cortisone. It holds most of a drop in the conjunctival sac, even though the patient may blink. When the patient does blink, the solution is caught on the eye lashes, and upon opening the eye, it flows back into the conjunctival sac.

Knowledge of its centipoise ranges is essential in prescribing methyl cellulose, he observes. In his experience, a 0.5-0.8 per cent solution of the 4,000 c.p.s. variety of this colloid has the optimal viscosity for ophthalmic solutions.

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From Our President

The Eightieth Annual Convention

Shortly after this issue of The Journal is received, many of you will be meeting together in Hollywood at the eightieth annual convention of the Association. I hope that you have made reservations early, so that you may be comfortably located.

Those of you who are delegates and alternates should by this date have studied the Handbook for Delegates and have determined what reports and resolutions you wish additional information about before you are ready to vote on them in the House of Delegates. If you have not been instructed by your local medical society, you are requested to appear before the reference committee to which these reports and resolutions are referred for study. This is the democratic way. No resolutions are discussed on the floor before reference to a committee for study and report.

Be prompt in reporting at the stated hour for meetings of the House of Delegates. A delegate once seated cannot later be replaced by his alternate. Prompt attendance at the General and Scientific Assemblies will be much appreciated by your officers. The opening session on Monday will be called on time.

You are invited to visit the various scientific and commercial exhibits. Because of their excellence they deserve more than your passing attention. You will find much of interest in the Exhibit Hall.

I am looking forward to meeting you again in Hollywood. We expect another fine convention. This is my "swan song." It has been a pleasure to talk to you each month through the President's Page in The Journal. God bless you all. See you in Hollywood.

Frederick K. Herpel

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Medicine Comes of Age
Healer-Scientist Union

One phenomenon of the remarkable acceleration of medical progress in the last half century is perhaps not yet readily appreciated in its true perspective and full significance. Today, the art of healing and the science of medicine, once separate and often antagonistic functions, have merged to the point where the impact of this fusion profoundly affects both physician and patient.

Old as recorded history, the art of healing is "the skilful and creative dispensing of any type of relief to the sick of body or heart;" it can be measured only in terms of the inspiration it evokes. On the other hand, the young science of medicine includes "all of the rich and demonstrable results of the application of man's intellectual faculties to problems related to his health." The union of the two is adequately appraised in The Saturday Review of January 9 by Dr. Dana W. Atchley, professor of clinical medicine at Columbia University College of Physicians and Surgeons and a long time staff member at New York's Presbyterian Hospital.[1] "Medicine as a whole," writes this distinguished physician, "came of age when the stature of the science grew large enough for it to combine with the art in mutual understanding and respect. This new medicine is still adolescent, but it is alive and growing and it exerts an influence far ahead of its years."

The art of the healer, whatever his methods, has ever had broad appeal to the ailing. The authoritarian approach, even though it cloak utter ignorance of disease processes, brings reassurance. Exhibition of genuine interest, an obvious desire to be helpful, sympathy and genuine compassion together with understanding of the personality and environment of the patient are the tools with which the healer may happily alter the patient's life while nature effects a cure. These qualities are basic necessities both to the grossest charlatan and the best trained physician. Had the healer been content not to supplement the psychologic approach with weird material therapy, thereby implanting a demand for spectacular demonstrations of a tangible nature, the sound development of the practice of medicine would have progressed more rapidly.

With the science of medicine yet in the embryonic stage, even the highest type of physician was dependent largely on the art of healing for the good he did. The urge for the spectacular, inherited from medicine man and magician,

pushed the revered family doctor of yesteryear into foolish procedures, too often actually harmful. Many a patient in need of a transfusion was bled white, and many another in need of better nutrition was starved. Gradually, however, the influence of the whole field of science with its steady substitution of hypotheses derived from experiment for dogma built on superstition has brought intellectual emancipation which is counterbalancing the traditions of the healer.

So rapidly has medicine come of age that Dr. Atchley pictures the medicine he learned on the wards of a university hospital in 1915 as presenting almost as sharp a contrast to that taught today as would the 1915 variety to that of Hippocrates 2,300 years earlier. He sees in the synthesis of healer and scientist two outstanding changes in the practice of medicine: the healer leading the way back to a primary preoccupation with the person as an individual human being, and the scientist contributing the power of analysis and integration that has led to the discarding of orthodoxy and illogical tradition.

As the healer has merged with the scientist, exposition has supplanted pompous authoritarianism, honest simplicity has replaced the complicated pseudoscientific double talk of "catarrhs," "intoxications," and "biliousness," and the "bedside manner," where it survives, is frankly salesmanship. Today's atmosphere is experimental, the mood is inquiring, the goal is understanding. The healer is as alert as the scientist, for there is as much concern with the understanding of the total individual as of his chemical processes.

"It is thus apparent," summarizes Dr. Atchley, "that the physician of today, at his best, represents a fusion of the healer and the scientist. In his role he analyzes the multiple components presented by a single human being. As healer his intuitive understanding of the personality and environment is amplified by modern psychology; and scientific studies of the many facets of the structure and function of the physical machine inform him as to the existing organic status. The appraisal resulting from an integration of these data leads naturally to the special management appropriate to the particular individual. The introduction of the highest possible standards of scientific precision into clinical medicine is no deterrent to the exhibition of compassion or any of the other generous gifts of the healer. Merging the healer and the scientist combines the best capacities of both and loses nothing by the union."

This evolution of the physician himself, his understanding, his wisdom, his philosophy, has been as important an influence in the great changes in medicine in the last 40 years as has been the general growth of medical knowledge. This evolutionary process, in turn, reflects the evolution of medical education. The medical school has emerged from a profitable side line for a group of successful practitioners to become an integral part of the university, manned by full time professors with freedom to undertake research. In this atmosphere of teaching, of learning, and of eager search for knowledge, present in medical schools across the nation, clinical medicine has matured, and the stature and usefulness of the physician of today have materially increased. Herein lies the key to medicine's future.

Older physicians will find perusal of Dr. Atchley's article rewarding as a portrayal of the changing role of the physician in the era of medicine's greatest progress, in which they have had a part. Younger physicians will find it stimulating, for it offers both inspiration and challenge as it delineates the large place into which they have been called as they integrate into the practice of their profession the art of healing and the science of medicine.

1. Atchley, D. W.: The Healer and the Scientist, The Saturday Review, Jan. 9, 1954, p. 7.

"Hundredth Birthday"

Marking the centennial celebration of the Duval County Medical Society, "Hundredth Birthday" is a story, mostly pictorial, which recounts the history of Florida's oldest medical society. With Dr. Webster Merritt serving as editor and historian and Dr. Joseph J. Lowenthal as associate editor, the centennial committee and officers of the society have published a history of general interest to the public. It is built upon a theme of medical activity in Jacksonville and Duval County during the last century which is woven into a loose fabric with historical events in Florida and concurrent national and worldwide events. Although the book was scheduled for publication last year — the centennial year — unexpected delays have made it available to the public only recently.

It was on May 25, 1853 that the physicians of Jacksonville met in the office of Dr. William J. L'Engle in the Republican Building on the

southwest corner of Bay and Market streets to form an association which today bears the name bestowed upon it at that meeting. The first officers of the Duval County Medical Society were Dr. John S. Murdoch, president; Dr. L'Engle, secretary; and Dr. Richard P. Daniel, treasurer. Largely responsible for the founding of the society was Dr. A. S. Baldwin, distinguished medical and civic leader of that early day. Dr. Baldwin, Dr. H. D. Holland and Dr. J. G. Dell were the other charter members. This first medical society in Florida remained the only one for two decades and 21 years after its organization was largely responsible for the founding of the Florida Medical Association.

"Hundredth Birthday" in pictorial review reverts, appropriately enough, to the early history of this area, depicting such notable events as the discovery of Florida by Ponce de Leon in 1513, the landing of Jean Ribaut and the French Huguenots in 1562 and the establishment of Fort Caroline by Laudonniere in 1564. Pictures and occasional detailed accounts cover the period of Andrew Jackson's rule as Florida's first provisional governor, the Indian War period featuring Osceola, the 1840-1860 period with the invention of the ice machine by Dr. John Gorrie, the period of the War Between the States, the Reconstruction period, and the various epidemics, especially the yellow fever epidemic of 1888 followed the next year by the founding of the Florida State Board of Health. The Spanish-American War period is included, with pictures featuring General Fitzhugh Lee and the officers and men stationed at Camp Cuba Libre in Jacksonville.

Familiar scenes of half a century ago in Jacksonville and along the St. Johns River add interest. The fire of May 3, 1901 which destroyed downtown Jacksonville is graphically covered and followed by pictures of the rebuilding of the city. Many national events also receive attention. There is recognition of leaders of the University of Florida and mention of its forthcoming School of Medicine at Gainesville. Medical frauds are not neglected, and there are numerous miscellaneous subjects.

A particularly notable feature is pictures of the past presidents of the Duval County Medical Society, 19 of whom were also presidents of the Florida Medical Association. Record is made of the steps by which the society in 1949 obtained a permanent building and thus established another first by becoming the first medical society in Florida to own its home.

This unique contribution to Florida's medical history should have peculiar appeal both in medical circles and publicly.

Shaler Richardson

The State Medical Society

Eighty years have come and gone since the Florida Medical Association was founded. In that period the world has undergone tremendous changes. So has the state medical society. As the Association gathers in Hollywood for its Eightieth Annual Meeting this month, no member needs reminding that every scientific step forward in the field of medicine has brought increasing complexities to the private practice of medicine. Personal experience attests this steady change. All realize, too, that with the progress of science the scientific functions of the state medical society have kept abreast of the times. The emphasis on the scientific program at the annual meetings and the broad expansion of postgraduate medical education reflect the scientific trend, as exemplified in our Association.

How many, however, pause to reflect on the nonscientific activities and problems of the state medical society? Our Association, for example, has grown and expanded remarkably, especially in recent years, until it now boasts a membership in excess of 2,500. This number is almost double that of a decade or so ago. The busy staff of the Executive Office now numbers 10. There are, in addition, the Board of Governors with its six subcommittees, some 20 regular committees, and several special committees. Serving on a voluntary basis, approximately 150 members of the Association man these committees. This figure does not take into account the numerous positions held, without pay, by the officers, members of the Board of Governors, councilors, delegates and others. Despite the changing times, the Association is still carried on in great part by voluntary workers.

Convention time is a particularly appropriate time to emphasize that the strength of the Association, as of any state medical society and of the entire medical profession for that matter, remains rooted in the individual physician. It depends upon his conduct; the better he serves his patients, the higher will be the regard in which the public holds the medical profession as a whole. It

behooves him to keep constantly in mind that the primary objective of the medical profession is to render service to humanity.

In this modern era of astonishing attainments, there may be many who have much, but there remain many, many more who have little. It is therefore incumbent upon the individual physician to give great consideration to the demands of the public for adequate medical care. Not alone the state medical society and its component county societies, but the whole structure of medicine and, in turn, the health of the nation rest upon the integrity, the willingness to serve and the success of the individual practitioner. In the words of John Ruskin, "The highest reward for man's toil is not what he gets for it but what he becomes by it."

Medical Forums Popular

During the winter season now ending, medical forums have been more and more popular with county medical societies in Florida. The idea originated in 1952 with the Pinellas County Medical Society, which has just completed its third annual series. So popular has been this innovation that three societies, the Dade County Medical Association, the Palm Beach County Medical Society, and the Polk County Medical Association, have for the second season presented a successful series. The societies conducting a forum for the first time this season were those of Duval, Hillsborough, Marion, Orange and Volusia counties. Others are in process of organizing such a program.

The forum as a means of disseminating information on health and disease in line with popular interest expressed through the public press was quickly adopted in other states. Joining with the county medical societies as co-sponsors, the local daily newspapers in Florida and elsewhere have given excellent cooperation in making this venture a success in many communities. Since their origin in Pinellas County, some 75 series of forums have been conducted throughout the country.

These forums are constructive and promote improved public relations between the laity and the profession. Their popularity in Florida should encourage their promotion by medical societies in all sections of the country. While they have particular appeal as a seasonal attraction in favored resort areas, as the initial St. Petersburg venture has proved, their popularity is nevertheless assured in any community in a position to sponsor them. Interest in authoritative health information is immune to climate.

Blood Publishes Abstracts in Interlingua

A new policy by Blood, The Journal of Hematology, is described as a major breakthrough in the great barrier of language. With its January 1954 issue, this internationally read journal became the first to publish summaries of its various articles in the new scientific "supranational" language, Interlingua.

Translated abstracts in one or another language are of course not new. For some time they have performed an important service in a limited way to limited groups, but there is always the question of which languages. Spanish has been a popular choice because of increasing awareness of Latin America and its growing integration into the sphere of North American medical influence. There are, however, the Brazilians whose language is Portuguese and the Haitians and some Canadians whose native tongue is French.

To solve this problem of which language, Dr. William Dameshek, Blood's editor, who is clinical professor of medicine at Tufts College Medical School in Boston, was quick to turn to Interlingua. When introduced to it by the Interlingua Division of Science Service and Dr. Alexander Gode of New York, he saw in it a more telling and more ambitious attack on the language obstacle. Dr. Dameshek explained editorially that this international or supranational language is based on the concept that "international language does not need to be invented. It exists. One only needs to collect all its words and set them in order." He quoted Dr. Gode as saying: "Strictly speaking, the language is not constructed but extracted. It aims to be simultaneously French, English, Spanish, Italian, and so on," each one of these languages streamlined according to a set plan.

Interlingua then is extracted and amalgamated out of Italian, French, English, Spanish and Portuguese combined. To be classified as international, a word must be used in at least three of these language units, with German and Russian as possible substitutes. Those who use the various romance languages should read Interlingua with ease. As this new language develops, there will

be contributions from German, Russian and Oriental languages.

Dr. Dameshek envisioned in Interlingua a harbinger of good will bringing humanitarian benefits that eclipse even its scientific advantages and usefulness. "The development of a common international tongue such as Interlingua," he predicted, "may not only aid in the means of communication between scientific groups, but in the gradual filtering down of the good-will engendered there to the masses of the people in general." Blood is to be commended for pioneering in this noteworthy project. This readily understandable new supranational tongue deserves success not alone in the limited sphere of medical and scientific circles but in the world at large.

German Doctors: A Study in Contrasts

The busy American physician will find it hard to believe that German doctors are burdened professionally with leisure. Reportedly, Germany has an army of 30,000 jobless or partially jobless doctors. Physicians are working as construction laborers, jazz musicians and circus roustabouts.

West German doctors unemployed or dependent on odd jobs outside their profession number more than 4,500. Some 18,000 more German doctors have all but deserted the medical profession for other careers. In addition, 8,000 postgraduate medical students are working without pay as interns.

Why do not these doctors utilize their training and follow the profession of their choice by entering the private practice of medicine? The explanation is given in an enlightening article from Bonn, the source of the information here presented, which appeared recently in Stars and Stripes, the Armed Forces newspaper: "The answer is the traditional German system of public health insurance, a system which has existed since Bismarck. Today, four out of five families are insured under the system." The article discusses in detail the inadequacies of this system as it exists today.

Ironically enough, East Germany is critically short of doctors. One doctor for every 2,000 inhabitants is the ratio. Furthermore, according to this story, food shortages and long working hours decreed by the East-zone Communist regime have brought a serious increase in illness.

Public Relations Potpourri

Words of wisdom public relations-wise from the sixth annual Medical Public Relations Conference held in St. Louis in late 1953:

"Medicine has outgrown the little black bag," said Dr. Walter B. Martin of Norfolk, Va., president-elect of the American Medical Association, in his keynote address. "Health is no longer entirely an individual matter between a physician and a patient." In his opinion problems that arise need careful joint exploration for the purpose of coordinating all health activities for the total benefit of the public. "I like to think of public relations," he continued, "not as a means of putting ourselves in a better light before the public, but as a way by which we can learn better how to serve the public and to constantly enhance the quantity and quality of medical care and its availability."

"Many adult patients expect the same understanding and attitude from their physicians, the same omniscience and the same omnipotence they believed their mothers possessed," observed Dr. Leo H. Bartemeier of Detroit, chairman of the A.M.A. Committee on Mental Health, who urged physicians to employ some of the general principles of psychiatry and to understand the feelings of anxiety, fear and insecurity which motivate some patients. "Repeated failure to understand patients in matters which are of a serious nature to them tends to motivate them away from medicine."

Commenting on efforts to smear medicine because of an alleged negative attitude, Mr. Roger Fleming of Washington, D. C., secretary-treasurer of the American Farm Bureau Federation, noted that "seven out of ten commandments start out 'Thou shalt not.'"

Mr. Rollen Waterson of Oakland, Calif., executive secretary of the Alameda-Contra Costa County Medical Association, presided over a symposium on "Mending Our PR Fences." He offered this prescription: "If we are to have good public relations with people, we have to back up what we say, be what we pretend to be and produce a uniformly good product."

Women Drivers Do Better

Not only do women differ from men in their driving characteristics and habits, but they also do better. In the matter of accidents, for example, only one woman in nine has an accident record, and approximately one in 25 has a violation record. The figures for men, however, are one in four for both accidents and violations. With regard to age, younger women have fewer accidents than older women, but older men have better driving records than young men.

There has been an appreciable increase lately in the proportion of women drivers in the population. The ratio was one in four in 1951, and in 1953 it was close to one in three. The average annual mileage for women is about one third that for men. Only about 20 per cent of the nation's annual mileage is credited to women drivers. Also, women have fewer years of driving experience.

Studies for the purpose of arriving at a practical system for judging driving efficiency brought to light these statistics. Dr. A. R. Lauer, Elmer B. Siebrecht and Charles F. Schumacher of the Iowa State College conducted this research and reported the results to the American Association for the Advancement of Science at its recent Boston meeting. They proposed a new index of accident susceptibility to take into consideration the experience of the driver and the mileage driven each year.[1]

1. Women Drivers Differ from Men: They Do Better, Science News Letter 65:41 (Jan. 16) 1954.

STATE BOARD OF HEALTH

Proposed Investigation of Ringworm of the Scalp

A study of the epidemiologic aspects of ringworm of the scalp is planned for several counties in Northeast Florida. There has been noted an increase in this disease by the State Board of Health through the county health departments. The purpose of this study is to attempt to identify the factors which increase the susceptibility of contacts in a case of ringworm of the scalp, and the cause of its spread through a community.

After ringworm is diagnosed by a physician and the case reported, a visit to the home will be made by a health department physician or nurse. An epidemiologic form will be completed which includes such items as habits, shampoos, hair characteristics, location of the lesion, and presence of household pets. Cultures will be obtained. With the attending physician's approval, a survey of therapeutic results will be made. A follow-up visit is to be made four months after the case is reported to determine the course of the disease and the spread to other members of the family.

Routine investigations will be made on all reported cases in those counties selected for this study. The investigations will be extended to other counties, however, if a sufficient number of cases are reported by the physicians, and time will permit their study.

It is hoped that from this study information can be obtained which will lead to a better understanding on the methods of control of ringworm of the scalp.

The reporting of all cases of ringworm of the scalp by the physicians of the state to the county health department will greatly facilitate this study.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Leo L. Nastasi of Miami announce the birth of a daughter, Antoinette, on Dec. 17, 1953.

Dr. and Mrs. Federico A. Smith of Miami announce the birth of a daughter, Laura, on Jan. 4, 1954.

Deaths — Members

Brown, Alan, Clearwater	Dec. 15, 1952
Britt, Otis W., Port St. Joe	Dec. 29, 1953
Holland, Howard G., Leesburg	Feb. 13, 1954
Norwood, John K., Jacksonville	Feb. 19, 1954
Granade, John E., Bradenton	Feb. 20, 1954
Roush, Dwight I., Pinellas Park	March 4, 1954
Roque de Escobar, Raul, Tampa	March 7, 1954

Deaths — Other Doctors

Barland, Samuel, Elmhurst, N. Y.	Nov. 27, 1953
Davidson, James W., Crescent City	Feb. 4, 1954
Strong, Samuel B., Lake Charles, La.	Feb. 6, 1954
McLester, James S., Birmingham, Ala.	Feb. 8, 1954
Moore, Thomas F., St. Petersburg	Feb. 10, 1954
Abbiss, Frederick J., Chipley	Feb. 24, 1954

NOTICE

Your March Journal carried a complete program and other detailed information relative to the Eightieth Annual Meeting of the Association in Hollywood, April 25-28.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Cox, Forest W., Fort Lauderdale
Fontaine, William C., Panama City
Hendrix, Joseph P., Port St. Joe
Houston, William H. Jr., Jacksonville
Joyce, Reid P., Sarasota
Luer, Carlyle A., Sarasota
McLeod, James A., Orlando
Nixon, James D., Panama City
Pennington, Luther T. Jr., Eau Gallie
Read, J. Sturdivant, Sarasota
Rickerd, Charles L., Daytona Beach
Robelen, Harry C. Jr., Fort Lauderdale
Safer, Jacob V., Jacksonville
Scott, Thomas F. Jr., Sarasota
Seymour, Charles F., Fort Lauderdale
Shaar, Richard T., Jacksonville
Shehee, Walter H., Chipley
Shippen, Eugene R. Jr., Orlando
Stanley, Gordon D., Sanford
Stansbury, Thomas C. Jr., Sarasota
Sutherland, William G., Sarasota
Turton, Murrell H., Fort Lauderdale
Wager, William F., Port St. Joe
Warden, Cyrus E., Melbourne
Wilson, Albert A., Tampa

The President will deliver his annual address at the first meeting of the House of Delegates, Tuesday morning, April 27.

STATE NEWS ITEMS

Dr. M. Eugene Flipse of Miami has been recalled to active duty with the U. S. Navy and is at present Head of the Chest Service at the U. S. Naval Hospital, Bethesda, Md.

Dr. C. Frank Chunn of Tampa has returned to his practice after appearing on the program at a recent meeting of the American College of Surgeons in Charlotte, N. C.

Dr. Clarence L. Brumback of West Palm Beach attended the meeting in February of the Florida Health Officers Conference of which he was chairman. The meeting was held in Jacksonville.

Dr. Lemuel F. Coxe Jr. of Panama City has been made a director of the Bay County Cancer Corporation.

Dr. George F. Schmitt Jr. of Miami spoke on the heart at a meeting of the 99's Breakfast Club in February.

Dr. William W. Miller Jr. of Pensacola spoke at a meeting of the Warrington Kiwanis Club in January. His subject was the diagnosis of urinogenital organ disorders and their treatment.

Dr. Louis M. Orr of Orlando spoke on a new way to avoid the harmful effects of the "wonder" drugs at a convention at the College of Medical Evangelists in February.

Dr. Wilson T. Sowder of Jacksonville presided at the annual Florida Health Officers Conference in Jacksonville in February. Dr. Sowder was recently named to the Southern Regional Education Boards' Mental Health Training and Research Commission.

Drs. Lucien Y. Dyrenforth, Nelson A. Murray, John B. Ross, Wray J. Tomlinson and Carl H. Wells of Jacksonville took part in the program at a Hematology meeting for Physicians and Medical Technologists held in that city in February.

Dr. Frederick J. Waas of Jacksonville, president of the Florida Chapter of the American College of Surgeons, attended a sectional meeting of the College in Charlotte, N. C. in February.

Dr. Kenneth A. Morris of Jacksonville has been named senior warden of St. John's Cathedral for the coming year.

Dr. Joseph M. Bistowish Jr. of Tallahassee has been named general chairman of the Florida Health Officers Conference to succeed Dr. Clarence L. Brumback of West Palm Beach.

Dr. Gretchen V. Squires of Pensacola spoke on cancer at a regular meeting of the Bay Memorial Hospital Auxiliary in February.

Dr. William Y. Sayad of West Palm Beach spoke on "Fenestration" at a meeting of District 9, Florida State Nurses Association, on February 18.

Dr. George R. Crisler of Winter Park spoke on "Health and Aging" at the Monday Evening Community Series held at the First Congregational Church on February 15.

Dr. J. Sudler Hood of Clearwater gave a talk on heart disease at the regular dinner meeting of the Largo Kiwanis Club on February 8.

Dr. Erasmus B. Hardee of Vero Beach attended the regional meeting of the State Boards of Medical Examiners of the United States in Chicago in February.

Dr. Richard G. Skinner Jr. of Jacksonville spoke to the North Florida Association for Retarded Children on the "Retarded Child Problem" at Pine Castle School in February.

Dr. Frederick H. Bowen of Jacksonville was presented a Certificate and check for $50 by the Duval County Medical Society for the best scientific paper within the Society last year. The winning paper was "The Treatment of Post-Thrombophlebitic Changes in the Legs By Various Surgical and Conservative Means," given at the Florida Medical Association meeting in Hollywood last April and published in The Journal, October 1953.

Dr. Gary E. Turner of Jacksonville took part in a panel discussion on the retarded child at a meeting of the Northeast Florida Association for Mental Health in January.

Dr. Eugene M. Frame of Jacksonville gave a talk at the February meeting of the Lakeshore School P.-T. A.

Dr. Chester Cassel of Miami spoke to the Miami Society of X-ray Technicians on February 1 on "Anatomy and Pathology of the Digestive Tract."

Dr. Leon M. Thurston of St. Petersburg recently celebrated his ninetieth birthday. Dr. Thurston, who still practices medicine when the need arises, was unfortunately in the hospital with a broken hip.

Dr. Sullivan G. Bedell of Jacksonville has been elected a vestryman of the Church of the Good Shepherd.

Dr. George H. Starke of Sanford received a scroll of honor for accomplishment in medicine at Negro Achievement Day at the Florida State Fair.

Dr. Clarence Bernstein of Orlando has been elected to the executive committee of the American Academy of Allergy.

Dr. William M. Bevis of Lakeland has joined the medical staff of Anclote Manor, Tarpon Springs, as resident psychiatrist and consultant. Anclote Manor was opened for the reception of patients on Dec. 28, 1953.

Dr. Frank G. Slaughter of Jacksonville spoke on "Jacksonville in Civil War Days" at a meeting of the Riverside Lions Club in January and on "What Jesus Christ Means To Me" at a recent Sunday evening service of the Riverside Presbyterian Church.

Dr. Ashbel C. Williams of Jacksonville spoke on cancer at the January meeting of the Jacksonville Dental Auxiliary.

The following members of the Florida Medical Association were registered at the Southeastern Division Regional Meeting of the International College of Surgeons, United States Section, held in West Palm Beach, January 29 and 30: Drs. Anthony D. Migliore, Arcadia; William D. Sugg, Bradenton; William R. Hutchinson, DeLand; Ernest Bostelman, Fort Myers; Joseph M. Burton, Homestead; Carl C. Mendoza, John H. Mitchell, G. Frederick Oetjen, Jacksonville; Joseph L. G. Lester Jr., Key West; Oswald A. Holzer, Melbourne; Ralph F. Allen, Edward R. Annis, George Ferré, Alexander Kushner, Claude G. Mentzer, Miami; Harold P. Auslander, Harold H. Fox, Maurice J. Rose, Miami Beach; Frank D. Gray, Eugene L. Jewett, Clarence W. Lynn, Don C. Robertson, Orlando; Harry Moses, Herman G. Rose, Bailey B. Sory Jr., Palm Beach; Julius C. Davis, Quincy; Vernon A. Lockwood, St. Augustine; Julien C. Pate Sr., Julien C. Pate Jr., Lee T. Rector, Tampa; Horace D. Atkinson, William E. Bippus, Edwin W. Brown, Joseph J. Daversa, S. Ward Fleming, Frederick K. Herpel, Theodore Norley, Lloyd J. Netto, James C. Nowling, S. Richard Ombres, Cecil M. Peek, Raymond S. Roy, James R. Sory, West Palm Beach; and Wiley T. Simpson, Winter Haven.

Dr. Hawley H. Seiler of Tampa recently spoke before the Isthmian Canal Zone Medical Association meeting held in the Gorgas Memorial Laboratory in Panama City, Panama. His topic was "Thoracic Problems of General Interest." He also addressed the Gorgas Hospital staff on "Indications for Pulmonary Resection."

Dr. James C. Rinaman of St. Cloud has returned to his practice after taking a one week postgraduate course sponsored by the American College of Chest Physicians in New Orleans.

Drs. Ruth S. Jewett, Winter Park, and Elwyn Evans, Orlando, were on a panel on "What Can Be Done About Heart Disease" on the weekly Orlando JayCee radio forum in February.

Dr. E. Frank McCall of Jacksonville talked on "Hypertension in Pregnancy" at a meeting of the Savannah, Ga., Obstetric and Gynecologic Society in January.

Dr. Thomas M. Palmer of Jacksonville was elected to the Board of Directors of the Children's Home Society of Florida at the Fifty-first Annual Meeting of the Society.

Dr. William M. Kummer of Lakeland spoke on "The Eye and Your Practice" at a meeting of the Morrell Memorial Hospital staff on February 16.

Dr. William H. Walters Jr. of Lacoochee spoke before the Dade City Rotary Club's weekly luncheon meeting on February 15. He told of the work of the American Heart Association.

Dr. George W. Morse of Pensacola spoke on "Nursing Aspects in the Care of the General Surgical Patient" at the meeting of District One of the Florida State Nurses Association in February.

Drs. Horace A. Day, Robert W. Curry, and David Y. Hicks Jr. of Orlando and Lorenzo L. Parks of Jacksonville led a panel discussion on cancer and patient care during the cancer nursing institute held in Orlando in February.

Dr. James V. Freeman of Jacksonville has been elected a vestryman of St. Mark's Episcopal Church.

Dr. John J. Fisher of Jacksonville gave talks on behalf of the March of Dimes Drive at meetings of many organizations in January.

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

SURGEON: Age 39, F.A.C.S. and Board Eligible, seeking association with older surgeon, or community in need of a well trained general surgeon. Has Florida license. Write 69-106, P. O. Box 1018, Jacksonville, Fla.

PHYSICIAN: Desires position or association. Age 44, licensed, excellent training in medicine with clinical and administrative experience including practice. Write 69-108, P. O. Box 1018, Jacksonville, Fla.

INTERNIST: Age 32, Florida license, Category IV, passed Part I Boards, desires practice location, association, partnership, small group, or industry. Willing to do limited general practice. Write 69-109, P. O. Box 1018, Jacksonville, Fla.

TISSUE TECHNICIAN: Five years Army and medical school laboratory experience in surgical, autopsy and research tissues including special stains. Write Miss Almira O. Duncan, 1029 Jackson St., Denver, Colo.

LOCATION DESIRED: ENT, Board Eligible, leaving military service mid-November. Interested taking over established practice or joining clinic. Broncho-Esophagoscopy, Plastic Surgery. Write 69-113, P. O. Box 1018, Jacksonville, Fla.

INTERNIST: Florida native and licensure, 29, Board Eligible. Desires association or community in need of well trained internist. Available June 1954. Write 69-114, P. O. Box 1018, Jacksonville, Fla.

OPHTHALMOLOGIST: University-trained, Board eligible. Native Floridian. Interested in group practice, prefer South Florida. Enter fall 1954. Will consider "clinic" or association with individual. Write 69-115, P. O. Box 1018, Jacksonville, Fla.

TO LEASE: To individual Doctors or Groups, New professional street floor offices on Hollywood Boulevard, in Hollywood, Fla., that will offer every convenience for the Doctor. Complete Bathroom, Treatment Room, Waiting Room, Office and Operating Room, Examination Room, Heated and well conditioned, Soundproof, with ample parking on the premises. Fall occupancy. Perfect location for Doctor and Patient. Write 69-116, P. O. Box 1018, Jacksonville, Fla.

SITUATION WANTED: Young, married, veteran, graduate Medical College of Georgia. Florida license. Internship Ohio State University Hospital. Desires association with group or individual, general practice, Florida. Write 69-117, P. O. Box 1018, Jacksonville, Fla.

GYNECOLOGIST-OBSTETRICIAN: Desires association with obstetrician-gynecologist, or group. Board eligible, very well trained, Florida license. Will attend medical convention in April in Hollywood. Write or wire 69-118, P. O. Box 1018, Jacksonvile, Fla.

COMPONENT SOCIETY NOTES

Dade

At the regular meeting of the Dade County Medical Association on March 2, a symposium on Tick Paralysis was held. Moderator was Dr. Wm. W. McKibben. Assisting were Drs. Edward Jaffe, Irwin Perlmutter and Charles C. Hillman; W. Henry Leigh, Professor of Parasitology and Zoology, University of Miami; James H. Heidt, entomologist; and Dr. Jack Knowles, veterinarian.

Duval

At the regular meeting of the Duval County Medical Society on March 2, Dr. Richard H. Overholt of Boston spoke on "The Direct Approach to Shadow and Substance." Dr. Overholt is clinical professor of surgery at Tufts College Medical School and operates the Overholt Thoracic Clinic.

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on March 2, Dr. George T. Harrell, Dean of the University of Florida College of Medicine, spoke on "Present Status and Future Plans for the University of Florida Medical College."

Jackson-Calhoun

Sixty doctors attended the annual scientific program of the Jackson-Calhoun County Medical Society in Marianna on February 5. Dr. Jabe A. Breland, president of the Society, presided at the meeting. Speakers were Dr. John T. Mauldin, associate professor of surgery at Emory University, who spoke on "Current Concepts of the Diagnosis and Management of Appendicitis," and Dr. Ted Leigh, professor of radiology at Emory University, who spoke on "Some Problems Related to the Diagnosis of Duodenal Ulcer." Dr. Walter Flint of Albany, Ga., spoke at the dinner held that evening.

Lake

The Lake County Medical Society held its regular monthly meeting at the home of Dr. H. Durham Young Jr. of Leesburg. Dr. James R. Boulware Jr. of Lakeland spoke on pediatrics. A barbecue dinner was served.

Madison

The Madison County Medical Society has paid 100 per cent of its state dues for 1954.

Marion

Dr. Raymond J. Fitzpatrick of Gainesville was the guest speaker at the March 16 meeting of the Marion County Medical Society. He spoke on "The Urinary Tract from the General Surgeon's Viewpoint." A discussion followed.

Orange

The Orange County Medical Society is presenting a series of free medical forums in the Municipal Auditorium, Orlando, during March and April. Dr. Robert L. Tolle is chairman of the series. The purpose of these forums is to give to the public factual information concerning some of the more common medical problems. There will be a formal talk of about ten or fifteen minutes by a qualified specialist in the field of the topic under discussion on each program. The remainder of the program will be used to answer questions sent in by the public. These questions will be answered by a panel of several doctors.

The dates and topics for discussion are as follows: March 3, Heart Disease; March 10, Cancer; March 17, Arthritis and Rheumatism; March 24, Growing Old Gracefully; April 15, Allergy; April 22, High and Low Blood Pressure. The programs will last one hour beginning at 8:30 p.m.

St. Johns

The St. Johns County Medical Society has paid 100 per cent of its state dues for 1954.

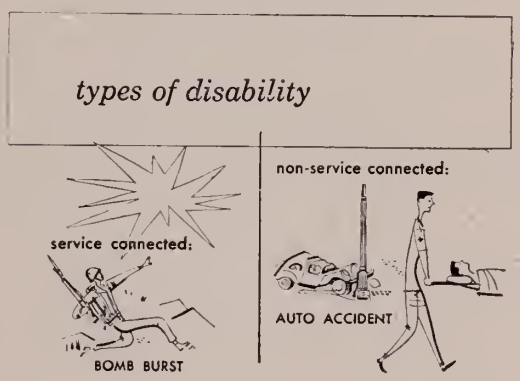
Volusia

Speaker at the regular February meeting of the Volusia County Medical Society was Mr. Hugh Hoke, pharmacist, of Daytona Beach. His subject was public relations.

Walton-Okaloosa

The Walton-Okaloosa County Medical Society has paid 100 per cent of its state dues for 1954.

In Viewing the VA Medical Program . . .



The medical profession fully endorses and supports the medical program of the Veterans Administration through which veterans receive medical care and hospitalization without cost for illnesses or injuries incurred as a result of military service (left). It is felt, however, that the federal government should not assume the responsibility for the medical care of veterans whose disabilities are incurred in civilian life and which have no relationship to their military service.

NOTICE

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OBITUARIES

Adam George Meister Jr.

Dr. Adam George Meister Jr., of Sarasota met accidental death in a plane crash on Nov. 17, 1953, near Fort Bragg, N. C. He was 30 years of age.

A native Floridian, Dr. Meister was born in Orlando on Aug. 6, 1923. He received his early education in Florida, attended Miami Senior High School and continued his schooling in Tennessee. After completing his premedical work at Southern Junior College, now Southern Missionary College, at Collegedale, Tenn., and Washington Missionary College at Tacoma Park, Washington, D. C., he attended the College of Medical Evangelists, Los Angeles, Calif. He was awarded the degree of Doctor of Medicine by that institution in 1947. After completing an internship at Jackson Memorial Hospital in Miami, he engaged in the private practice of medicine in Sarasota in association with a classmate, Dr. Karl R. Rolls.

In October 1952, Dr. Meister was called to active duty with the Army and joined the paratroopers the following December, being assigned to the 82nd Airborne Division, Fort Bragg, N. C., as a regimental surgeon with the rank of captain. The ranking officer and only one of 40 paratroopers remaining aboard a C-119 "Flying Boxcar" when it crashed, he had waited until all his men had jumped, meeting his untimely death in line of duty.

During the four years that Dr. Meister practiced in Sarasota, he was on the staff of the Sarasota Municipal Hospital and during his last year there was secretary of the Obstetrical Section. He was an active member of the Seventh Day Adventist Church, serving as an elder for two years and holding numerous other positions. Active in alumni work, he was secretary-treasurer of the Florida Chapter of the College of Medical Evangelists Alumni Association in 1952.

Dr. Meister was a member of the Sarasota County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association and the American Academy of General Practice.

Surviving are the widow, the former Edwina Smith of Chattanooga, Tenn.; five children, Joan, 7, Jean and Jane, twins, 4, George III, 2, and Robert Edwin, 4 months; his mother, Mrs. Thelma Stokes of Miami; his father, Adam G. Meister Sr., of St. Petersburg; and an uncle, H. L. Meister of Miami.

George Nowlan MacDonell

Dr. George Nowlan MacDonell of Miami died on Dec. 8, 1953. He was 80 years of age.

A native of Georgia, Dr. MacDonell was born in Savannah in 1873. He was graduated from the Atlanta College of Physicians and Surgeons in 1905. The first Methodist missionary to go to Cuba, he arrived there in 1898, during the last days of Spanish rule, and remained there three and a half years. In November 1899, Dr. MacDonell contracted yellow fever, the scourge of Cuba and South Florida at that time. He was treated by Dr. Carlos Finley, who first insisted that yellow fever was transmitted by mosquitoes, and by Dr. William C. Gorgas, then an Army major, two of the great men of yellow fever fame, and later he studied the disease in all its phases under Gorgas. He then spent some time in Mexico and was superintendent of a Monterrey hospital in 1903 during a yellow fever epidemic. Thereafter he served as superintendent of Wesley Memorial Hospital in Atlanta for two years before becoming acting assistant surgeon general of the United States Public Health Service.

In 1926, Dr. MacDonell moved to Miami from Waycross, Ga., and became associated with the city health department. Later that year he was named chief of the division of health and in 1933 became Miami's first director of public health. Some eight years later he led a successful crusade to establish a countywide health unit, which automatically abolished the Miami director's post, but he accepted a place in the county health unit and continued to maintain an active interest in its work throughout his life. Until his retirement two years ago, as health officer he visited the Homestead clinic one day each week.

Dr. MacDonell in 1935 launched a long but successful battle for pasteurization of milk, finally winning out over wealth, politics, prejudice and ignorance. He fought just as courageously for a

Miami program to control yellow fever. His efforts to enforce stringent regulations in regard to mosquito protection for Dade County as aviation daily brought in visitors from yellow fever countries pioneered the way for much of the present mosquito control program. During World War II, he headed the medical service division of the Dade County Defense Council.

Dr. MacDonell and his wife observed their golden wedding anniversary on Jan. 29, 1950. In recent years they had devoted much time to an orchid collection which became nationally famous. He was a former president of the Orchid Society of Florida.

This distinguished member of the Dade County Medical Association had for 27 years been a member of the Florida Medical Association, holding honorary status the last three years. He was also a member of the American Medical Association, the American Military Surgeons, the International Association of Medical Health Officers, the Visiting Nurses' Association and the Dade County Tuberculosis Association. He was a past president of the Florida Public Health Association.

Surviving are the widow, Mrs. Mabel MacDonell; three sons, George N. Jr., Thomas K. and Robert C.; one daughter, Mrs. Margaret Farley; and 12 grandchildren. All reside in the Miami area.

Alvin Quincy English

Dr. Alvin Quincy English of Palmetto died on Dec. 4, 1953 from complications following injuries suffered in an automobile accident a week earlier. He was 72 years of age.

The oldest of 10 children of the late Jack and Carolyn Armanda English, Dr. English was born at Plant City in September 1881. After graduation from the Plant City High School, he taught school for a time before entering the Atlanta College of Physicians and Surgeons. He was awarded the degree of Doctor of Medicine by that institution in 1912.

The following year, Dr. English entered the general practice of medicine in Palmetto and continued to practice there for 40 years. Locally, he was a member of the First Baptist Church and also held membership in the Plant City Masonic Lodge.

Dr. English was a member of the Manatee County Medical Society, the Florida Medical Association and the American Medical Association. He was physician for the Seaboard Air Line Railroad Company.

Surviving are the widow, Mrs. Mildred S. English; one daughter, Mrs. Douglas Auld of Sarasota; four brothers, Emory English of Dade City; Clyde, Paschal and Scott English, all of Plant City; five sisters, Mrs. Harvey Dawson and Miss Rowena English of Tampa, and Mrs. Bernice Davis, Mrs. Tesco Johnson and Mrs. Seymour Sparkman of Plant City; and one granddaughter.

Walker Ely Swift

Dr. Walker Ely Swift died at his home in Sarasota on Dec. 20, 1953, following an attack of coronary thrombosis. He was 59 years of age and had been ill for some time.

Born in New York City in 1894, Dr. Swift was awarded the degree of Bachelor of Arts by Yale University in 1915. He received the degree of Doctor of Medicine in 1919 from Columbia University College of Physicians and Surgeons. An internship served at Presbyterian Hospital in New York City was completed in 1920. Additional training included a fellowship in physiology at Harvard Medical School and a fellowship in surgery at his alma mater. Following a residency at the New York Orthopedic Hospital, he qualified as a diplomate certified by the American Board of Orthopedic Surgeons. He then taught at Columbia University College of Physicians and Surgeons and was also Assistant Professor of Orthopedic Surgery of the New York Polyclinic Medical School and Hospital. In New York he served on the staff of a number of hospitals including Lenox Hill, Goldwater Memorial, Doctors Hospital, Memorial Hospital, Seaview Hospital, Sharon Hospital, Englewood Hospital, New York Orthopedic Hospital and Elizabeth A. Horton Memorial Hospital.

Dr. Swift came to Sarasota from New York in 1950 and since that time had been active in local medical circles. He was a member of the staff of Sarasota Municipal Hospital and also served as consultant in orthopedic surgery to the Sarasota County Association for Crippled Children and Adults. He was a member of the Ro-

tary Club of Sarasota and retained membership in the Century Club of New York City.

A member of the Sarasota County Medical Society, Dr. Swift also held membership in the Florida Medical Association and the American Medical Association. In addition, he was a member of the American Academy of Orthopedic Surgeons.

He is survived by his widow, the former Helen Gately of Brookline, Mass., to whom he was married in 1945. Other survivors are three children by a former marriage, Abbott M., Elizabeth V., and Dr. Lucy H. Swift, all of New York City, and two sisters, the Misses Marian and Nathalie Swift, also of New York City.

Whedon Johnson

Dr. Whedon Johnson of Sarasota died in a local hospital on Dec. 19, 1953, following an accident 10 days previously. He was 37 years of age.

Dr. Johnson was born in Syracuse, N. Y., in 1916. He was graduated from Harvard University in 1940 and received his medical degree from the Johns Hopkins University School of Medicine in 1943. Following an internship at the Johns Hopkins Hospital, he served in the Army of the United States as a captain and was surgeon at the Quartermaster Depot, Alexandria, Va. Upon discharge from military service, he became Associate Professor of Anesthesia at the University of Maryland School of Medicine.

In 1952, Dr. Johnson came to Sarasota from Baltimore and had practiced there only one year at the time of his death. He was keenly interested in developing electronics for use in his medical practice. He was a member of the staff of the Sarasota Municipal Hospital.

Dr. Johnson held membership in the Sarasota County Medical Society, the Florida Medical Association and the American Medical Association.

In 1940 Dr. Johnson was married to Miss Mary Townley Cobb, who survives him. Four sons, David, Whedon, Peter Cobb and Philip Ross also survive, and his mother, Mrs. Florence Johnson, of Syracuse, N. Y.

James Clarence Griffin

Dr. James Clarence Griffin of Tampa died on Dec. 13, 1953. His untimely death at the age of 39 resulted from the crash near Wimauma of an airplane which he owned and piloted.

A native of Florida and descendant of pioneer Florida families, Dr. Griffin was the son of the late James Clarence Griffin and Emilie Z. Griffin, both of Dade City. He was born there on April 9, 1914. After attending the public schools of Dade City, he received the Bachelor of Arts degree from the University of Florida before entering the University of Tennessee College of Medicine, where he was awarded the degree of Doctor of Medicine in 1938. There followed two years of hospital service in which he completed an internship and a residency in surgery at the Tampa Municipal Hospital.

Dr. Griffin then entered the private practice of medicine in Tampa in association with the late Dr. L. B. Mitchell. His specialty was surgery. Locally, he was on the staff of the Tampa Municipal Hospital, St. Joseph's Hospital, and the Tampa Negro Hospital. In addition, he was assistant surgeon of the Seaboard Air Line Railroad Company, official examining physician for the Civil Aeronautics Association, physician for the Air Cadets at the University of Tampa while that program was active, and surgeon for the Trans-Canada Air Lines. He held an ATR pilot's license. A member of St. Andrew's Episcopal Church, he also held membership in the Egypt Temple Shrine, Scottish Rite, Tampa Elks No. 708, Palma Ceia Golf Club, and Tampa Yacht and Country Club.

During World War II, Dr. Griffin held the rank of lieutenant in the United States Navy and served with distinction in the Pacific theater of operations. He was examining physician for the local draft board No. 1.

Dr. Griffin was a member of the Hillsborough County Medical Association, Florida Medical Association, American Medical Association, American Association of Industrial and Railway Surgeons, Southeastern Surgical Congress, Aero Medical Society, and International College of Surgeons.

The widow, Mrs. Mary Quinn Griffin, survives, as does also his mother, Mrs. Emilie Z. Griffin of Dade City.

(Continued on page 756)



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(Continued from page 754)

Samuel Frederick Smith

Dr. Samuel Frederick Smith of Lakeland died at the Morrell Memorial Hospital in that city on Dec. 14, 1953. He was 80 years of age.

Born in Marietta, Ohio, Dr. Smith attended Stetson University, where he was awarded the A.B. degree in the first graduating class. He received his medical degree from the Eclectic Medical College in Cincinnati in 1901 and engaged in postgraduate study at Wills Eye Hospital, Polytechnic Clinic and Jefferson Hospitals in Philadelphia, and also in New York.

Dr. Smith was licensed to practice medicine in Florida in 1901. He located in Leesburg, where he was a member of the city council for some years. He also served two terms in the state legislature, 1903 and 1907, from Lake County. In 1907 he moved to Lakeland, where he had continued to practice for 46 years. His specialty was ophthalmology and otolaryngology. Locally, he was a charter member of the Rotary Club and a member of Lakeland Lodge F.&A.M., the York Rite bodies and also the Egypt Shrine Temple of Tampa. He was a past president of the Lakeland Chamber of Commerce. A member of All Saints' Episcopal Church, he had for many years served as vestryman there.

Dr. Smith was a founder and charter member of the Polk County Medical Association and had been active in that society since its organization in 1910. He became a member of the Florida Medical Association in 1911 and had been a life member for three years. He was also a life member of the American Medical Association.

Survivors include a son, Dr. S. F. Smith Jr., of Memphis, Tenn.; a grandson and a granddaughter; a stepson, Carl A. Kern of Lakeland; and a brother, George R. Smith of Fruitland Park.



John Hightower Cooper

Dr. John Hightower Cooper of Commerce, Ga., formerly of St. Petersburg, died on Nov. 14, 1953 at the home of his sister, Mrs. H. F. Bray, in Commerce. He was 66 years of age.

Born in 1887, Dr. Cooper was graduated from the Atlanta College of Physicians and Surgeons in 1913. He then served an internship at Grady Hospital in Atlanta before entering military service during World War I. He was discharged from the Medical Corps of the Army in 1919 with the rank of captain.

Dr. Cooper then specialized in ophthalmology and otolaryngology in New York and afterward was affiliated with the Wesley Long Hospital in Greensboro, N. C. In 1925, he located in St. Petersburg, where he continued to practice his specialty until heart disease with complications caused his retirement in 1946. From that time



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until his death he resided with his sister in Commerce.

A member of the Pinellas County Medical Society, Dr. Cooper had for 28 years been a member of the Florida Medical Association. For nine years he had held honorary status. He was also a member of the American Medical Association.

Neil Alford

Dr. Neil Alford of Jacksonville died at his home on Jan. 17, 1954. He was 76 years of age.

A native of South Carolina, Dr. Alford was born in Mullins in 1878. He attended Wofford College at Spartanburg and in 1907 received the degree of Doctor of Medicine from the University of Nashville Medical Department in Nashville, Tenn. He also pursued his medical studies at the Medical College of the State of South Carolina at Charleston.

Dr. Alford engaged in the general practice of medicine in Miami before coming to Mayport in 1912 as a public health officer. He served in that capacity until 1918, and since that time had engaged in private practice in Jacksonville. Locally, he was a member of Solomon Lodge 20, F. & A. M., the Morocco Temple of the Shrine and the Loyal Order of Moose. For his service to the Armed Forces during World War II he received three Presidential citations.

Dr. Alford was a past president of the Dade County Medical Association, a member of the Duval County Medical Society, and for 32 years had been a member of the Florida Medical Association. He was also a life member of the American Medical Association.

Surviving are the widow, Mrs. M. Louise Alford, of Jacksonville, and several nieces and nephews in South Carolina.



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Raymond Julian Dalton

Dr. Raymond Julian Dalton, Monroe County health officer, died at his home in Key West on Jan. 18, 1954. He had suffered a heart attack in October 1953 while directing "Operation Gamma Globulin" to protect Key West children against the threat of a polio epidemic. He was 58 years of age. Interment took place in Milwaukee, Wis.

Born in Milwaukee on July 9, 1895, Dr. Dalton was educated in his native city. He received the B.A. and M.A. degrees from Marquette University and in 1919 the M.D. degree from the School of Medicine of that institution. After postgraduate work at Lying-In and Bellevue hospitals in the fields of obstetrics and gynecology, he engaged in the private practice of medicine in Milwaukee from 1921 to 1940. Thereafter he served for three and a half years with the Civilian Conservation Department of Wisconsin. Following that assignment, he spent one year in the Canal Zone as civilian physician with the federal government and then returned to serve one year with the Y. and O. Coal Company of West Virginia in industrial medicine.

Dr. Dalton came to Florida in July 1945 to accept the post of health officer in Lake County with headquarters at Tavares. He left that position two years later to re-enter the field of industrial medicine with the American Cyanamid Company at Brewster. In January 1952, he was appointed Monroe County health officer with headquarters in Key West, a position which he held at the time of his death.

A member of the Monroe County Medical Society, Dr. Dalton was also a member of the Florida Medical Association and the American Medical Association. In addition, he held memberships in the Florida and American Public Health associations.

Survivors include the widow, Mrs. Joan Dalton.

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Maximillian Ramsey Mansfield

Dr. Maximillian Ramsey Mansfield of Coral Gables died unexpectedly on Jan. 20, 1954 following an acute coronary occlusion. He was 43 years of age. Interment took place in Newburgh, Ind.

Dr. Mansfield was born in Bloomfield, Ind., in 1910. He attended Butler University and the Indiana University School of Medicine, where he received the degree of Doctor of Medicine in 1937. His hospital training was all in Indianapolis. In World War II he was a captain in the Medical Corps of the Army from 1941 through 1945, serving for two and a half years in field hospitals during the African and European invasions.

In 1946, Dr. Mansfield came to Miami Beach, where he practiced his specialty of otorhinolaryngology for a short time with Dr. Robert E. Repass before opening his own office in Coral Gables. He was on the staff of Doctors, Jackson Memorial, Mercy and Variety hospitals. His interests outside his profession included ceramics, painting, astronomy and fishing.

Dr. Mansfield was a member of the Dade County Medical Association, Florida Medical Association, American Medical Association and Southern Medical Association. He also was affiliated with the International Council for Exceptional Children and was a participant in the Miami Medical Forum.

Surviving are the widow, Mrs. Helen Mansfield; one daughter, Pamela Lee; his mother, Mrs. L. Mansfield; and two brothers, Richard of Newburgh, Ind., and Wayne of Detroit.



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BOOKS RECEIVED

Review of Physiological Chemistry. By Harold A. Harper, Ph.D. Ed. 4. Pp. 328. Price, $4.00. Los Altos, Calif., Lange Medical Publications, 1953.

This book presents the fundamentals of physiological chemistry with emphasis on the accepted facts and concepts of the subject. A concise presentation of the applied and established principles is favored over that of the theoretical and controversial. Intended as a supplement to the standard texts in biochemistry and as a companion volume for the student in such courses, the book contains much material drawn from the author's lectures in basic science given in conjunction with the graduate training of physicians. Thus it serves well as a review for the physician preparing for state and specialty boards and as an aid in keeping physicians abreast of this rapidly expanding branch of medical science which contributes much to the understanding and practice of all phases of medicine.

In this fourth edition the coverage of certain topics has been considerably expanded because of recent intensive research in these areas of physiological chemistry. This expansion enables the book to serve better the varied demands of the wide audience it has enjoyed. The author is Professor of Biochemistry at the University of San Francisco and Lecturer in Surgery at the University of California School of Medicine in San Francisco.

Cure Your Nerves Yourself. By Louis E. Bisch, M.D., Ph.D. Pp. 247. Price, $3.50. New York, Wilfred Funk, Inc., 1953.

For the many persons who find the tensions of modern life almost unendurable this heartening, practical book demonstrates that recourse to psychiatric treatment is not essential in a great majority of cases. In the light of 42 years' experience as a practicing psychiatrist Dr. Bisch, noted author and teacher, describes here 10 types of disturbances, so common as to be almost universal in some degree: dread of insanity; fear of suicide; self consciousness; anxiety; compulsions; fears in general; hypochondriasis; unhappy love affairs; sexual maladjustment and marital difficulties. His friendly and informal guidance helps the reader to understand his inner self and get at the basic causes of disturbances. Then he offers suggestions for banishing those tensions which destroy peace of mind and vitality. The reader learns how to help himself over the emotional maladjustments he can recognize and cure without expensive professional help.

The Rockefeller Foundation. Annual Report, 1952. Dean Rusk, president. Pp. 405. Free on request. Rockefeller Foundation, 49 West 49th Street, New York, 1953.

The 1952 Annual Report of the Rockefeller Foundation became available in September. Appropriations made during 1952 exceeded $16,600,000, and of this amount nearly $3,600,000 was applied to work in medicine and public health. Distribution was in the fields of investigation and control of specific diseases and deficiencies, professional education, medical care, development of the health sciences, fellowships, grants in aid, field service expenses and miscellaneous. The sum of $275,000 was set aside for 1953 virus investigations by staff members. The report contains an 84 page section on the Division of Medicine and Public Health in which the worldwide activities of the Foundation in this field are described.

Nervous System. Volume 1, The Ciba Collection of Medical Illustrations. By Frank H. Netter, M.D. Pp. 143. Price, $6. Summit, N. J., Publications Department, Ciba Pharmaceutical Products, Inc., 1953.

This compilation of pathologic and anatomic paintings of the nervous system is the first volume of a new series planned to portray in desirable detail the anatomy and pathology of all the systems comprising the human organism. There are 104 full color paintings with descriptive text and a comprehensive subject index. Ten plates depict the anatomy of the spine, 22 the central nervous system, 20 functional neuroanatomy, 20 the autonomic nervous system and 32 the pathology of the brain and spinal cord.

The principal aim of this atlas is to serve the practicing physician and the student in their efforts to understand the underlying reasons for and conditions of diseases and clinical syndromes. So popular was a book of illustrations by the talented artist-physician, Dr. Frank H. Netter, published five years ago by Ciba Pharmaceutical Products, Inc., that this firm commissioned the gifted medical illustrator to undertake this new project as another of its contributions to the progress of medicine. This book, dealing exclusively with the nervous system, represents the first step in the new direction and is supplied at cost.

The Nursing Mother, A Guide to Successful Breast Feeding. By Frank Howard Richardson, M.D., F.A.C.P., F.A.A.P. Pp. 204. Price $2.95. New York, Prentice-Hall, Inc., 1953.

Released in September 1953, this book is the first to be published in the United States which is designed specifically to help the average mother enjoy the benefits and satisfactions of breast feeding. It answers her questions, banishes doubts, and, if she is physically able to nurse her baby, assures her of a completely successful experience.

The author, an eminent pediatrician, author and lecturer, outlines here why "the breast-fed baby is the best fed baby," briefs the expectant mother on numerous details of equipment and preparation, and describes the nursing period down to the last detail, even to the father's participation at this important time. In addition, there is a comprehensive list of questions and answers for ready reference, dispelling the many old wives' tales about nursing.

Distinguished pediatricians and obstetricians commend the book highly as most helpful to young mothers and also to young physicians. Dr. Wilburt C. Davison, Dean and Professor of Pediatrics, Duke University School of Medicine, commented: "The benefits to be derived from breast feeding, for both mother and child, are enormous . . . Dr. Richardson's book places in the mother's hands all of the arguments for breast feeding and answers all of the questions which have arisen during the years. It is highly recommended. . ."

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Films in Psychiatry, Psychology & Mental Health. By Adolf Nichtenhauser, M.D., Marie L. Coleman and David S. Ruhe, M.D. Pp. 269. Price, $6.00. New York, Health Education Council, 1953.

The aims of this book, published in October 1953, are twofold: (1) to make films in psychiatry, psychology and mental health education more useful to more people, and (2) to begin to set higher standards of quality for making better new films in this important area of medical science.

The grist of this unique volume is a series of 51 penetrating, critical reviews of films in psychiatry, psychology and mental health, presented from the broad viewpoint of the medical audiovisual educator and made by the Medical Audio-Visual Institute of the Association of American Medical Colleges. This study is supplemented by brief descriptions of 50 additional significant and available films in this area released for showing up to January 1953. Four chapters are devoted to an analysis of the cumulative meaning of these reviews. There are also eight pages of dramatic scenes from the films and two complete indices by film subject matter and audience suitability.

A major contribution to health and medical education in their broadest and most specific outlooks, this book is described as "a new whetstone for sharpening the audiovisual tools of health education in all fields." It should be of interest to audiovisual educators generally for pointing new directions in the evaluation and production of films in all fields where audiovisual methods produce more incisive and illuminating instruction. While it offers no "cut and dried" formulas, it provides useful shortcuts for independent approaches to psychiatric teaching with films. Too, it is an important contribution to better public information in the broad field of mental health education.

The book was compiled under grants from the Rockefeller Foundation, the John and Mary Markle Foundation, the Commonwealth Fund, the Alfred P. Sloan Foundation and the China Medical Board.

It's NOT All in Your Mind. By H. J. Berglund, M.D., and H. L. Nichols, Jr. Pp. 343. Price, $3.95. Greenwich, Conn., North Castle Books, 1953.

The central theme of this book is consideration of whether physical ailments arise principally from physical or from mental causes. The authors hold that the technics of some psychiatrists and analysts, who during the last two decades have urged a new concept of healing called psychosomatic medicine, are of value in a limited field and give promise of wider future application. Their claims, however, they regard as far ahead of anything they have proved or accomplished, and they are causing serious harm to both the practice and the spirit of physical medicine. The damage arises chiefly from a perversion of their doctrines to serve as an excuse to ignore ailments which make up a substantial fraction of national suffering.

The purpose of the book, therefore, is to assemble in one place a simple explanation of the mechanisms of mind and body which are involved in personality and its effect on disease; the nature of psychoanalysis, and of psychosomatic theory and practice; and of the undeniable physical basis of allergy, glandular difficulties, and back pain. Included is an extensive discussion of allergy, intended to lift the stigma of neurosis and indicate ways in which it is relieved and cured by cooperation of physician and patient.

The authors hope that this work will help to check the swing away from physical realities toward the no-man's land of the emotions. Dr. Berglund was a nurse before she obtained her medical degree, and her experience with patients who had suffered unnecessarily and severely because of mistaken ideas that their symptoms were imaginary or emotional led to the production of this book. Her husband, Herbert L. Nichols, Jr., himself an author, collaborated with her in the writing of the book. Dr. Berglund has her own practice in New York and Connecticut, and specializes in problem cases of allergy.



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Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 249 applicants who took the examination of the Board, held November 23 and 24, 1953, in Jacksonville, 173 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 173 successful applicants follow:

Akins, Ernest William Jr., Miami (Louisville 1953)
Albert, Richard Orvil, Jacksonville (Texas 1947)
Anderson, Donald Carl, Pensacola (Minnesota 1945)
Anderson, William Arnold Douglas, Coral Gables (Toronto 1934)
Antreasian, Berj, Miami (Indiana 1953)
Appen, Raymond Carl, Durham, N. C. (Duke 1953)
Arnold, Carl Jackson Jr., Atlanta, Ga. (Emory 1946)
Asbury, Clyde Ellis Jr., Wilkes-Barre, Pa. (Northwestern 1945)

Bandy, Preston Hite, Gallatin, Tenn. (Tennessee 1946)
Barratt, William Edward, Mitchell AFB, N. Y. (Pittsburgh 1943)
Bascove, Selig Jack, Coral Gables (Jefferson 1949)
Beam, Curtis Edward, Miami (Arkansas 1953)
Bernstein, Mayer, St. Petersburg (Long Island Col. Med. 1916)
Berry, Carl Ziegler, St. Petersburg (Cincinnati 1939)
Bianchi, Dominick Anthony, Jacksonville (Hahnemann 1938)
Bieber, Gustave Francis, Stockton, Calif. (Duke 1943)
Bolton, John William, Miami (Johns Hopkins 1949)
Bracken, John Street, Sarasota (Northwestern 1947)
Brendle, Luther Alexander, Ocala (Tennessee 1931)
Bryan, Donald McIver, Mulberry (Vanderbilt 1953)
Burger, Leo Lester, Bushnell (Buffalo 1913)
Burns, Margaret Dorothy, Miami Beach (Pittsburgh 1953)
Burr, Janice Marion, Miami (Buffalo 1953)
Burroughs, Lyle Wendell, Mineral Wells, Tex. (Washington 1948)

Carlisle, James Mallory, Campbellton (Temple 1932)
Caster, Milton Philip, Coral Gables (Vanderbilt 1949)
Church, Marguerite Louise, Bradenton (Temple 1949)
Coffer, Robert Henry Jr., Warrington (Emory 1947)
Coggins, Robert P., Augusta, Ga. (Georgia 1951)
Colbert, Walter Thomas, Baltimore (Louisiana State 1947)
Coller, Jerome Joel, Orlando (Maryland 1950)
Connar, Richard Grigsby, Durham, N. C. (Duke 1944)
Cook, James Randel, Cleveland Heights, O. (Indiana 1944)
Cooney, James Francis, Rochester, Minn. (Yale 1946)
Cox, Franklin Homer, South Miami (Wayne 1951)
Cunningham, Gene Clayton, Tampa (Indiana 1953)

Daly, Roswald Bernard, Waxhaw, N. C. (Bowman Gray 1946)
Davis, Earl Scott, Naples (Illinois 1938)
Denham, Sam Wesley, Jacksonville (Emory 1946)
Dickinson, Thomas Gilford, Pensacola (Syracuse 1945)
Dillon, Charles Fulwood Jr., Orlando (Medican Evangelists 1953)
Dippy, Theodore Albert, Orlando (Emory 1953)
Duckworth, Alda Grey, Orlando (Indiana 1949)
Dunsworth, William Peter, Tampa (St. Louis 1952)

Edmark, Karl William, Nampa, Ida. (Colorado 1948)
Ellis, Ernest Behling, Miami (South Carolina 1943)
Evans, Walter Lee Jr., Coral Gables (Virginia 1946)

Feaster, Burns Lynn Jr., Lakeland (Tennessee 1948)
Ferguson, William Holmes, Miami (Geo. Washington 1953)
Fiero, Rollin Peter, Speculator, N. Y. (Michigan 1929)
Fleming, Burton Ailes, Tampa (Temple 1953)
Flynn, William Emmett, Baldwin, N. Y. (New York U. 1950)

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Franzino, Arthur Francis, Hollis, L. I., N. Y. (New York U. 1953)
Frell, Albert Calabria, Bloomington, Ill. (Ohio State 1942)
Friedman, Leo, Brookline, Mass. (Germany 1936)
Funt, Tobias Roger, Baltimore (Geo. Washington 1950)
Furr, Walter Eugene Jr., Cleveland Heights, O. (Northwestern 1947)

Gaetano, Peter, Miami (Ecl. Med. Col. Cincinnati 1927)
Gair, David Ramsey, Miami (Rochester 1953)
Galluccio, Joseph Richard, Fort Lauderdale (New York Med. Col. 1934)
George, Joseph Paul, Miami (Georgetown 1953)
George, William M., St. Petersburg (Pittsburgh 1952)
Gibson, William James, New Rochelle, N. Y. (Rush 1937)
Giffin, Allyn Bruce, Gulfport (Temple 1948)
Gladsden, Norman, Miami (Jefferson 1953)
Gleaton, Carroll Wayne, Tampa (Temple 1953)
Goldfarb, Irwin, Miami Beach (Illinois 1952)
Graybill, Robert Ernest, Orlando (Hahnemann 1953)
Green, David Erbie, Jacksonville (Tulane 1953)
Greene, John Randall, Miami (Ohio State 1953)
Grier, Arnold, Miami Beach (Chicago Med. Sch. 1952)

Harden, John Maxwell, Greenville, S. C. (South Carolina 1943)
Heffernan, John Albert, North Miami Beach (Marquette 1943)
Heydrich, Alfred Laurent, Orlando (Havana 1941)
Hilbert, Gerard Henry, Pensacola (Louisiana State 1947)
Holder, William Lewis, Miami (Maryland 1953)
Holmes, Charles Martin, Coral Gables (Maryland 1952)
Hubener, Louis Frederick, Baltimore (Arkansas 1935)

Jacobs, Shirley Louise Levin, Miami Beach (Pennsylvania 1952)

Kafka, Richard Michael, Tampa (Emory 1946)
Katims, Robert Bernard, Miami (Washington 1952)
Kitchen, Lloyd, San Francisco (Emory 1950)
Klinghoffer, Max, Elmhurst, Ill. (Illinois 1941)
Koenig, George Henry, Gulfport (St. Louis 1917)

Lambert, Charles Richard, Hollywood (Louisville 1947)
Langley, Thomas Ellison, Eustis (Duke 1952)
Langston, Mary Christine, Lakeland (Washington 1953)
Lenit, Oscar Sidney Jr., Chicago (Illinois 1952)
Llanes, Carlos Gilberto, Coral Gables (Havana 1945)
LoPresti, Gaetano Aleardo, Fort Lauderdale (Tufts 1951)
Love, Fred William, Delray Beach (Vanderbilt 1945)
Lyons, Robert Douglas, New Orleans (Harvard 1949)

McCoy, George Andrew, Washington, D. C. (Indiana 1937)
McGehee, Nat Tipton Jr., Miami (Georgetown 1953)
McLeod, James Alexander, Florence, S. C. (Cornell 1945)
McNally, Francis Joseph, Palmer, Mass. (Columbia 1944)
McNamara, Ronald John, Charleston, W. Va. (St. Louis 1930)
McWhorter, Robert Ligon Jr., Durham, N. C. (Duke 1947)

Maas, Paul, Miami (State U. Iowa 1953)
Maclure, John Grant, Miami (Vanderbilt 1953)
Mannis, Ben Gale, St. Louis (Arkansas 1940)
March, Alfred Leonard, Miami (Middlesex 1943)
Martini, Taverno A., Tampa (Col. P & S, Boston 1947)
Menta, Julius Daniel, Miami (Loyola 1947)
Menzies, Paul Thomas, Miami (Ohio State 1953)
Merkin, Alvin, Miami Beach (Jefferson 1952)
Miale, John Buyer, Miami (Rochester 1940)
Miller, Allen Lane Jr., Pensacola (Tulane 1946)
Mirow, Richard Raymond, Merrick, N. Y. (Maryland 1934)
Moon, Cary Nelson Jr., Charlottesville, Va. (Virginia 1944)
Moss, Herschel Conrad, Centerpoint, Ind. (Indiana 1950)
Mullins, Sylvester Delon, Emory Univ., Ga. (Georgia 1949)
Multach, David, Belle Glade (Illinois 1951)
Murray, Louis Charles, Orlando (Hahnemann 1953)

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Neal, John Basil, Jacksonville (Syracuse 1953)
Nisi, Fred Paul, Miami (Georgetown 1953)
Notarius, Morton Shelton, Miami (Illinois 1952)

Parker, Howard Andrew, Valparaiso (South Carolina 1951)
Pattengale, Nell Treva, St. Petersburg (Illinois 1929)
Peacock, Avon Jackson Jr., Chiefland (Bowman Gray 1953)
Perretti, Alfred P., Jacksonville (Louisville 1948)
Pinks, David King, Jersey City, N. J. (Georgetown 1937)
Pittman, James Allen Jr., Orlando (Harvard 1952)
Poppell, Jay Harris, Lakeland (Temple 1953)
Portin, Bertram Allen, Miami (Buffalo 1953)
Pratt, Jean Paul, Detroit (Johns Hopkins 1910)

Reams, Gerald Brock, Miami (Northwestern 1952)
Robbins, Frank Thayer, Emory Univ., Ga. (Emory 1952)
Robinson, Melvin Samuel, Orlando (Hahnemann 1953)
Rogers, Wayne Spitz, Brooklyn (Cornell 1949)
Romano, Randolph, Framingham, Mass. (Middlesex 1940)
Root, Samuel Woodson, Oak Ridge, Tenn. (Michigan 1943)
Rudnick, Joseph Herbert, Coral Gables (St. Louis 1944)
Rumsch, Bernard James, Miami Beach (Switzerland 1950)
Ryle, Winfred Edgar, Overland, Mo. (Alabama 1950)

Saber, Robert Herbert, Long Branch, N. J. (Netherlands 1953)
St. Mary, Edward William, Miami Beach (New York U. 1950)
Saltzman, Edward Jacob, Camp Kilmer, N. J. (Jefferson 1949)
Saphire, Enoch Joseph, Brooklyn (Columbia 1951)
Scarlet, Joseph James, Miami Beach (Pittsburgh 1953)
Schanze, John Kenneth, Coral Gables (Louisville 1953)
Segal, Milton, Mansfield, O. (Virginia 1945)
Silverman, Frederick, Miami Beach (Indiana 1953)
Simkus, Albert Andrew, Shreveport, La. (Harvard 1948)
Steele, Robert George, Jacksonville (Albany 1953)
Stengel, William Frederick, Pittsburgh (Pittsburgh 1945)
Steplock, Albert Louis, Port St. Joe (Tulane 1949)
Storch, Sidney, Jacksonville (Belgium 1939)
Stroup, Paul Eugene, Seattle (Jefferson 1952)
Szabo, Imre, Orlando (Buffalo 1952)

Taylor, William Martin, Sarasota (Emory 1953)
TenEyck, Edward Auprince, Fort Lauderdale (Cornell 1948)
Theodorou, George, Miami Beach (Greece 1944)
Thompson, Paul Margrave, Miami (Indiana 1952)
Torrance, Harold Robinson, Orlando (Syracuse 1953)

Underwood, Russell Spaldon, Miami (Duke 1951)

Vale, Henry Edmund Peter, New Smyrna Beach (Toronto 1926)
Vance, John Robert, Orlando (Hahnemann 1953) *(Deceased)*
Vanden Bosch, Jay Henry, Miami (Syracuse 1951)
Vann, Enoch James Jr., Vero Beach (Tennessee 1948)
VanWagenon, Nan, Washington, D. C. (Temple 1952)
Vinoski, Bernard Benedict, Miami Beach (Pittsburgh 1953)
Vomacka, Robert Phillips, Sarasota (Cornell 1950)

Walker, Earl Edward Jr., Brunswick, Ga. (Emory 1952)
Weiner, Harry S., Bloomfield, N. J. (Dalhousie 1941)
Wellborn, Walter H. Jr., Tampa (Emory 1946)
Wells, Peter Frailey, Daytona Beach (Pennsylvania 1946)
White, John Blackshear Jr., Headland, Ala (Tulane 1946)
Wickman, Kathleen R., Headland, Ala. (Nebraska 1943)
Williamson, James Wingfield, Miami (Temple 1953)
Wilson, Robert Rudolph, Shreveport, La. (Tulane 1952)
Wood, Frederic H., Hammond, Ind. (Albany 1944)

Yost, Orin Ross, Ormond Beach (Med. Col. Virginia 1930)

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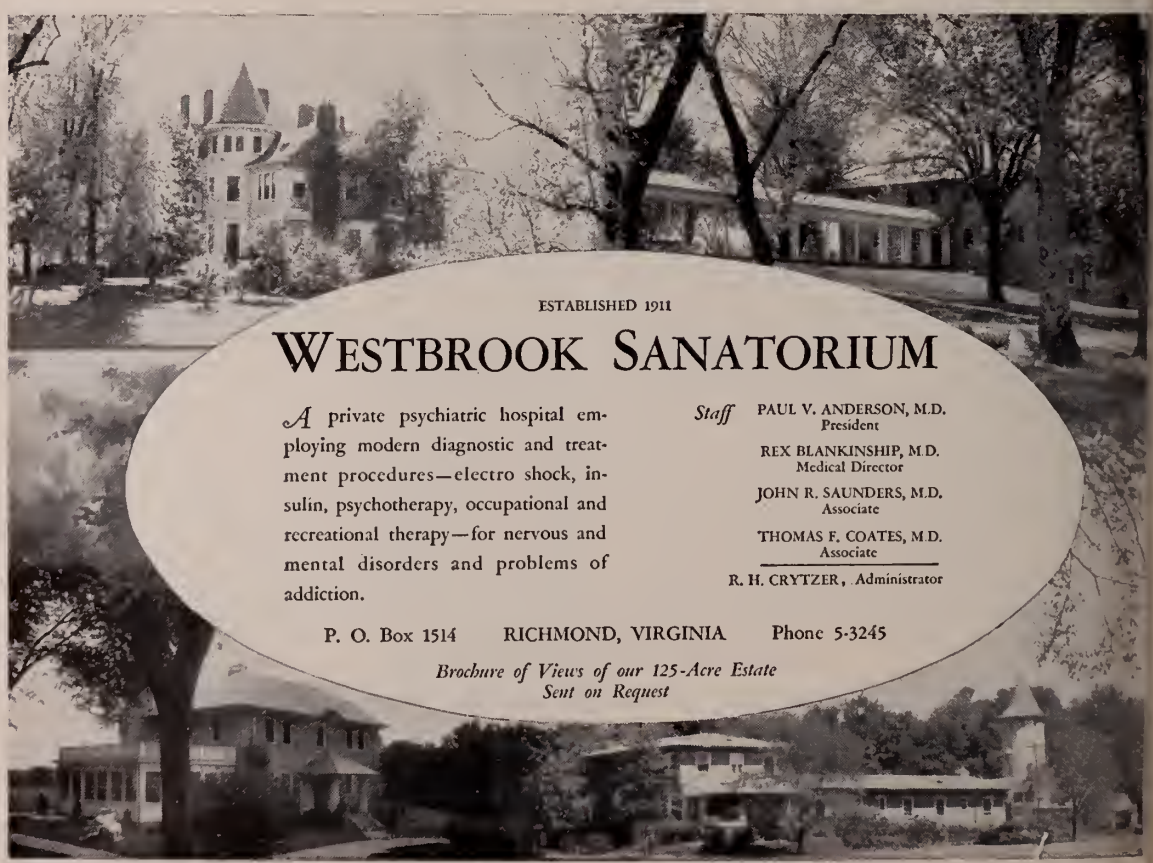
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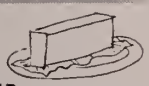

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*Average of American beers

"...use a little wine for thy stomach's sake and thine often infirmities..."

—Paul

The use of wine in nutrition and in medicine dates back to the beginning of history. It is recorded in the ancient Egyptian papyri, in the Bible—as in the oft-quoted admonition from Paul to Timothy—and in epicurean and medical annals from Hippocrates down to our own times.

In recent years there has developed a demand within the medical profession that the true values of wine be determined, and that fact be separated from folklore. Accordingly, fifteen years ago, research projects in many American medical centers were initiated to determine by modern scientific techniques the food values and medical uses of wine.*

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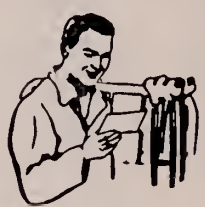
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Lakeland	206 Marble Arcade
West Palm Beach	305 Citizens Building
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Sarasota	1369 Main Street, Room 15
Daytona Beach	116½ Orange Avenue
Pensacola	501 Theisen Building

SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
...Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	Hollywood, Apr. 25-28, '54
...Medical Districts	John D. Milton, Miami	Council Chairman	
...rthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
...rtheast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
...uthwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
...utheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
...Specialty Societies			
...y of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	Hollywood, Apr. 25, '54
...Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	" "
...siologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	" "
...r, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	" "
...nd Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	" "
...Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	" "
...ial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	" "
...gy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	" "
...Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	" "
...l. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	" "
...edic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	" "
...gists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	" "
...ic Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	" "
...gic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	" "
...gical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	Hollywood, Apr. 24-25, '54
...cal Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	Hollywood, Apr. 25, '54
—			
...Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
...l Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
...Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
...Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	Hollywood, Apr. 25, '54
...r Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
...al Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
...l Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	Daytona Beach, Apr. 25-28 '54
... Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	Miami, Apr. 29-May 1, '54
...tal Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
...al Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
...al Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, July 12-16, '54
... Anesthetists, Fla. Assn.	Miss G E. Keyes, Daytona Beach	Mrs. Lillie Crouch, Daytona Beach	Atlanta, April '54
...s Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
...naceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May 10-12 '54
... Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
...au Society	Hawley H. Seiler, Tampa	John G. Chesney, Miami	St. Petersburg, Apr. 9-10, '54
...rculosis & Health Assn.	Leffie M. Carlton Jr., Tampa	Mrs. L. C. Conant, Fort Myers	" "
...n's Auxiliary	Mrs. Thomas C. Kenaston, Cocoa	Mrs. Lee Rogers Jr., Cocoa	Hollywood, Apr. 25-28, '54
...n Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
...A Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
...n Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
...n Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	Mobile, Apr. 15-17, '54
... Medical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
...spital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	Atlanta, Apr. 6-8, '54
...stern Allergy Assn.	W. Lindsay Miller, Gadsden, Ala.	Kath. B. MacInnis, Columbia, S. C.	
...stern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	Palm Beach, April, '54
...stern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
...st Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22, '54



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
**Bradford, Gilchrist, Union*				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	106
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	11
**Baker, Hamilton*				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	659
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	261
**Clay*				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	92
**Santa Rosa*				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	178
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	19
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	26
**Sumter*				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	35
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	55
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	21
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	29
**Levy*				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	178
**Osceola*				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	131
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	206
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	93
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	9
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	18
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	18
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
**Dixie, Lafayette*				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	83
**Flagler*				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	17
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
				Total 2,530

*Supervise and aid until organized separately

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If the patient complaining of aching joints is a woman between 37 and 54 years of age, it is highly possible that she is suffering from arthralgia rather than arthritis.[1] It has been estimated that arthralgia occurs in about 40 per cent of women with estrogen deficiency, and is exceeded in frequency only by symptoms of emotional or vasomotor origin.[2] In fact, arthralgia may be as indicative of declining ovarian function as the classic menopausal hot flushes.

Arthralgia, however, is just one of a vast number of distressing but ill-defined symptoms that may be precipitated by the loss of estrogen as a "metabolic regulator." Other good examples are insomnia, headache, easy fatigability, and tachypnea.

Because these symptoms sometimes occur years before or even long after cessation of menstruation, they are not always readily associated with estrogen deficiency, and the tendency may be to treat them with medications other than estrogen. Obviously, sedatives and other palliatives cannot be expected to produce a satisfactory response if an estrogen deficiency exists. Only estrogen replacement therapy will correct the basic cause of the disorder.

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1. Greenblatt, R. B., and Kupperman, H. S.: M. Clin. North America *30*:576 (May) 1946. 2. McGavack, T. H., in Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 225.

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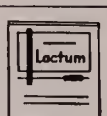
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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XL MAY, 1954 No. 11

IN THIS ISSUE

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Arthur J. Logie and William M. Howdon

Tung Nut Poisoning
Edward Balthrop, William B. Gallagher, Thomas F. McDonald and Sam Camariotes

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Volume XL | MAY, 1954 | No. 11

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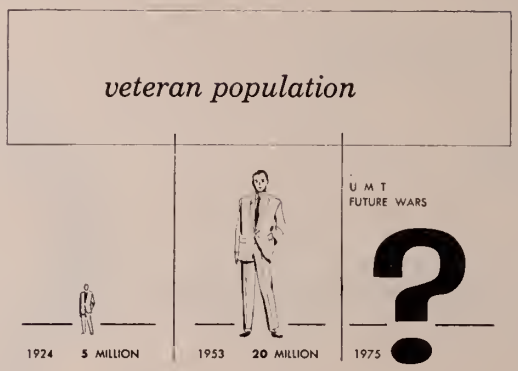
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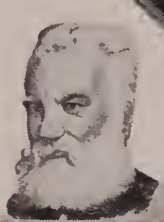
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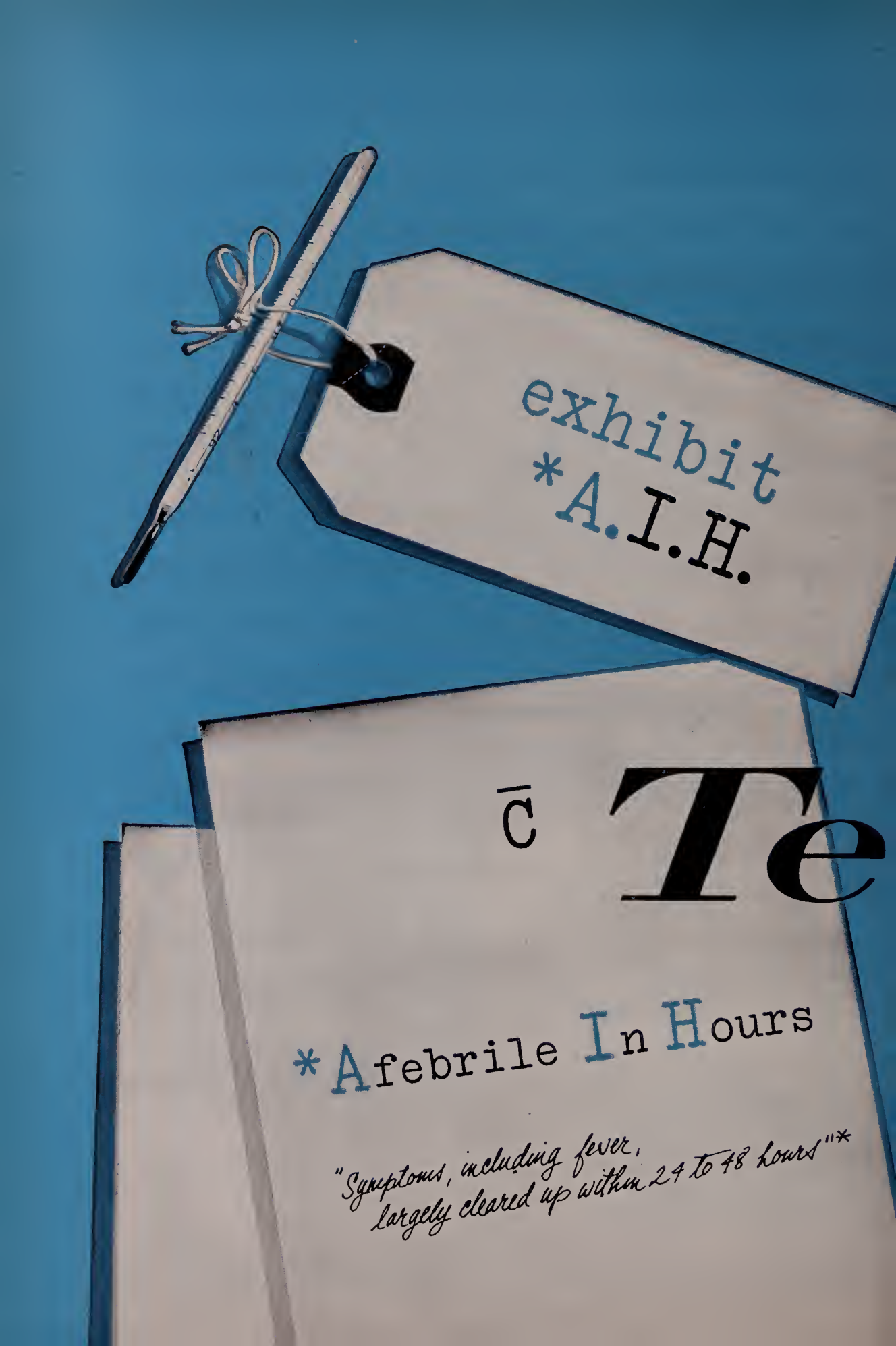
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1. Abramson, Julius, Bresnick, Elliott, and Sapienza, P. L.: *New England Jour. Med.*, 243:44, July 13, 1950.

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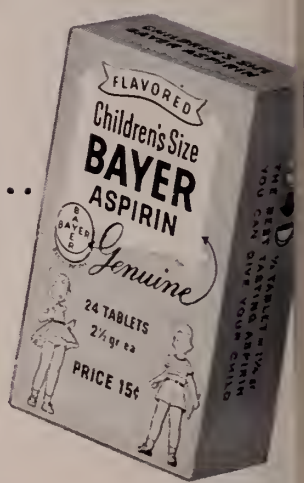
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1. Werner, A.: Acta endocrinol. *13*:87, 1953.
2. Malleson, J.: Lancet *2*:158 (July 25) 1953.
3. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc., 1953, p. 23.

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From a practical dietary standpoint, meats-in-a-can—preserved by commercial canning—are nutritionally interchangeable with meats of like variety prepared in the home.[1] For taste appeal, for economy and "keeping" quality, and for household convenience, meats-in-a-can are advantageous in many respects.

As the comparative data here shown indicate, kitchen-prepared meats and similar meats-in-a-can are closely alike in the amounts of various nutrients they provide.

COMPARATIVE COMPOSITION OF KITCHEN-COOKED AND COMMERCIAL-CANNED MEATS
(Nutrient Amounts per 100 Grams)

	*Kitchen-Cooked Ham[2]	**Canned Ham[3] (Chopped, Cured)	Kitchen-Cooked Beef Round[2]	Canned Roast Beef[2]
Water	50%	50%	59%	60%
Protein	21 Gm.	20 Gm.	27 Gm.	25 Gm.
Fat (ether extract)	28 Gm.	20 Gm.	13 Gm.	13 Gm.
Niacin	4.0 mg.	4.3 mg.	5.5 mg.	4.2 mg.
Riboflavin	0.21 mg.	0.19 mg.	0.22 mg.	0.23 mg.
Thiamine	0.46 mg.	0.40 mg.	0.08 mg.	0.02 mg.

*Values after conversion from 42% to 50% water basis.
**Values after conversion from 58.69% to 50% water basis.

Experimental studies have shown that the processing which meats-in-a-can undergo leads to little if any greater vitamin losses than does home-cooking of similar cuts of meat. In general, meats-in-a-can retain of their original vitamin content approximately:

60 to 80 per cent of thiamine
90 to 100 per cent of riboflavin
90 to 100 per cent of niacin
80 per cent of biotin
70 to 80 per cent of pantothenic acid.[4,5]

During storage for customary periods, at usual warehouse temperatures, meats-in-a-can show little, if any, further vitamin loss except in thiamine. Even thiamine, a highly thermolabile vitamin, was 52 per cent retained in pork-in-a-can after ten months' storage at 80° F. Retention of the vitamin was notably greater when the canned pork was stored at 38° F.

Since meats-in-a-can are thoroughly cooked in processing, they may be consumed as purchased, merely warmed or mildly cooked. When the meat is moderately cooked in preparation for consumption, little or no further loss in vitamins need to occur.

Recent studies show that meats-in-a-can are excellent sources of needed amino acids.[6] The 18 amino acids determined in these studies appeared in similar ratio and amounts in canned beef, pork, and lamb as in the respective fresh or home-cooked meats.

1. Howe, P. E.: Foods of Animal Origin, Handbook of Nutrition, American Medical Association, ed. 2, Philadelphia, The Blakiston Company, 1951, p. 637.

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4. Rice, E. E., and Robinson, H. E.: Am. J. Pub. Health *34*:587 (June) 1944.

5. Schweigert, B. S.: Am. Meat Inst. Foundation, Circular No. 8, Nov. 1953.

6. Schweigert, B. S.; Bennett, B. A.; McBride, B. H., and Guthneck, B. T.: J. Am. Dietet. A. *28*:23 (Jan.) 1952.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

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4 Hypotensive action is independent of alterations in heart rate.

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11 Tolerance or idiosyncrasy rarely develops; allergic reactions have not been encountered. Hence tablets Veriloid can be given for the long treatment needed in severe hypertension.

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1. Kauntze, R., and Trounce, J.: Treatment of Arterial Hypertension with Veriloid (Veratrum Viride), Lancet 2:1002 (Dec. 1) 1951.
2. Wilkins, R. W.: Combination of Drugs in the Treatment of Essential Hypertension, Mississippi Doctor *30*:359 (Apr.) 1953.
3. Stearns, N. S. and Ellis, L. B.: Acute Effects of Intravenous Administration of a Preparation of Veratrum Viride in Patients with Severe Forms of Hypertensive Disease, New England J. Med. *246*:397 (Mar. 13) 1952.
4. Moyer, J. H., and Johnson, I.: Intramuscular Veriloid (Aqueous Solution) As a Hypotensive Agent, Am. J. M. Sc. *226*:477 (Nov.) 1953.

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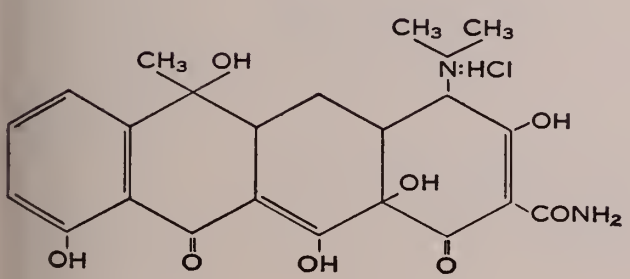
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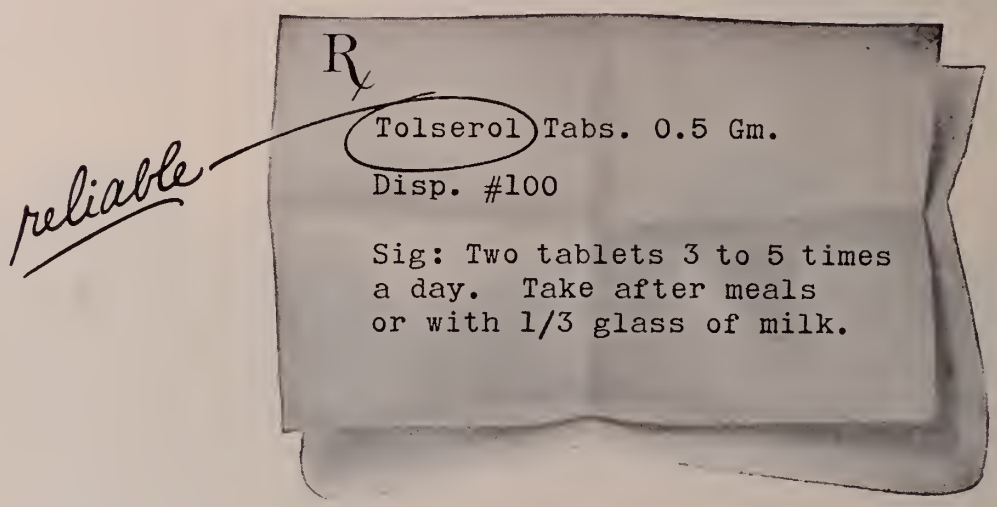


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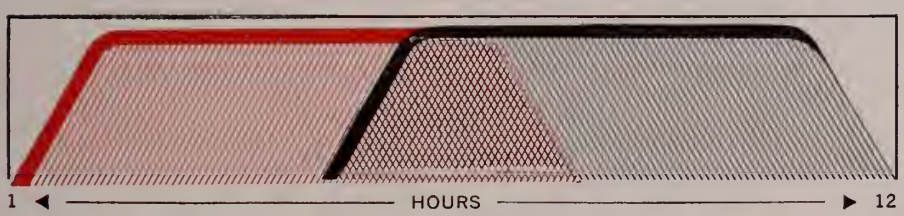
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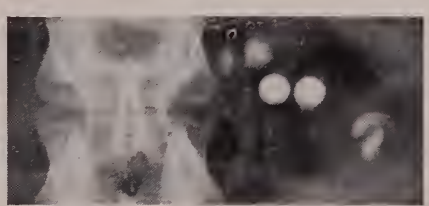


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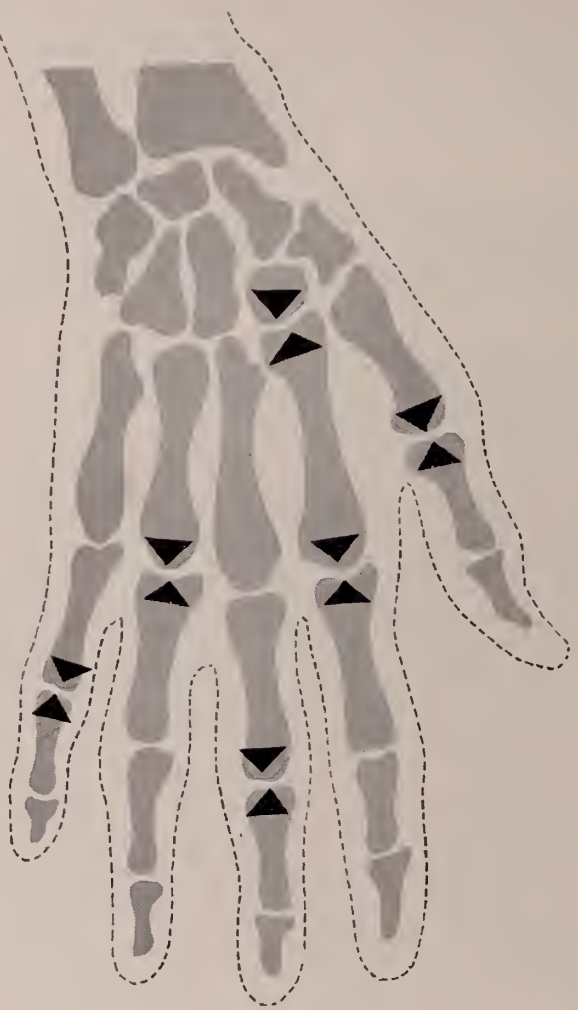
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The Histopathology of Adenomatous Polyps of the Colon and Rectum

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The pathologic diagnosis and treatment of adenomatous polyps of the large intestine have been subjects of controversy for the past 60 years. The purpose of this communication is to discuss the problem from the standpoint of the pathologist.

The pathologist's problem concerns itself with the answer to the following questions: (1) What constitutes malignancy in adenomatous polyps of the large intestine? (2) Do adenomatous polyps have a tendency to become malignant? (3) What is the biology of carcinomatous polyps of the large intestine? The treatment largely depends upon the answer to these questions.

Criteria for Malignancy

Not all pathologists agree as to what constitutes malignancy in adenomatous polyps of the large intestine. David[1] thought that the only criterion was invasion. Swinton and Warren[2] and Helwig[3] were of the opinion that two of the following three criteria had to be present for malignancy: (1) anaplasia, which includes difference in size, shape and staining quality of cells and their nuclei, hyperchromatism of nuclei with typical and atypical mitotic figures, and increased nucleus/cell and nucleolus/nucleus ratios, (2) irregularity of architecture, which includes extensive stratification of cells, intraglandular budding, and great variation in polarity of nuclei, and (3) invasion. The reason for the difference of opinion is that a group of polyps exists in which the glandular formations have some but not all of the attributes of malignancy, or they have all of the attributes to a slight degree.

In our laboratory, we follow the general principles outlined by Bacon, Laurens and Peale.[4] We divide these polyps into: (1) adenomatous polyps with no atypism, (2) adenomatous polyps with atypism, and (3) adenocarcinoma developed in an adenomatous polyp. In group 1, the adenomatous structures are straight with little branching. The component cells show no difference in size or shape. Both they and their nuclei are regularly oriented with respect to the lumen. There is no stratification of cells nor mitotic figures (fig. 1). In group 2, the cells show some degree of atypism. That is, the glands are somewhat tortuous with or without papillary projections. The component cells show a slight degree of altered polarity, and there may be pseudostratification. The nuclei are somewhat hyperchromatic, and mitotic figures may be in evidence. The degree of change is insufficient, either from the standpoint of quality or quantity of attributes, to be designated frank anaplasia (fig. 2). The tumors in this group are also considered to be benign. In the third group, frank anaplasia is present. There may or may not be disruption of the basement membrane or invasion of the stalk or base (figs. 3 and 4).

Tendency of Adenomatous Polyps to Become Malignant

There is no question that carcinomas may develop in certain adenomatous polyps. The question is — does this mean that there is a transformation of benignity into malignancy, and that the polyp predisposes to carcinoma? Or is the development of carcinoma a coincidence? Or has

From the Department of Pathology of the Mount Sinai Hospital of Greater Miami, Miami Beach.
Read before the Florida Proctologic Society, Sixth Annual Meeting, Hollywood, April 26, 1953.

the malignant polyp been malignant from the beginning? Statistical evidence is conflicting in this respect. The fact that the sigmoid colon is the most common site of adenoma, of adenocarcinoma developing in an adenoma, and of carcinoma has been brought to bear in favor of the potential malignancy of adenomatous polyps.[3] On the other hand, many carcinomas develop in a bowel without polyps, and only about 7 per cent of benign polyps may eventually show malignancy.[3] The

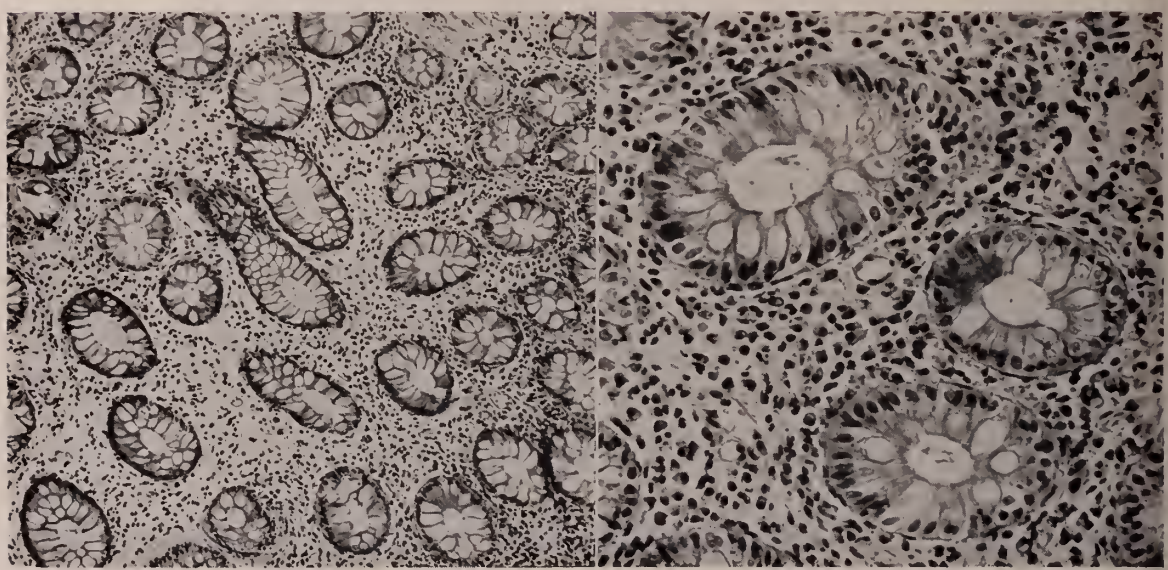


Fig. 1.— Adenomatous polyp with no atypism. Hematoxylin-eosin stain. (a) X96 (b) X300.

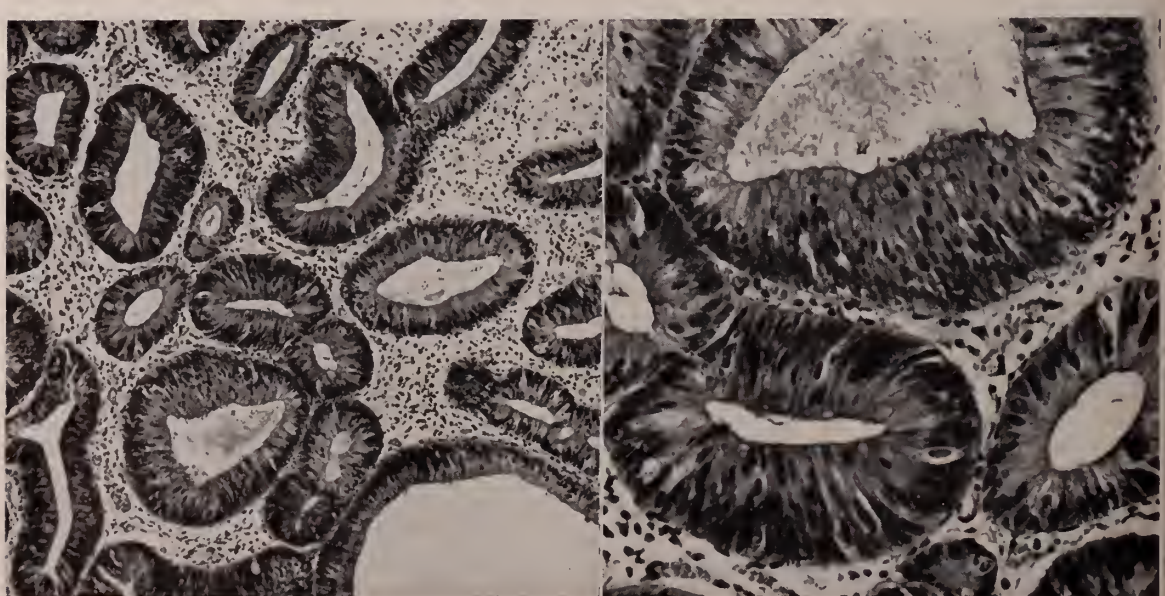


Fig. 2.— Adenomatous polyp with atypism. Hematoxylin-eosin stain. (a) X96 (b) X300

universal development of carcinoma in multiple polyposis of the colon has been presented as evidence of malignant predisposition of adenomatous polyps.[5] On the other hand, this is a relatively rare heredity condition, and not necessarily related to the usual polyps of the colon.[6] Thus the question of predisposition towards malignancy of adenomatous polyps cannot be answered today.

In our laboratory, we proceed in the following manner (fig. 5). The entire specimen is fixed in formalin for 24 hours. We then cut the stalk and its attached portion of mucosa and polyp away from the outer parts of the polyp. The latter are then cut into the approximately same thickness as this middle portion. All of these are then placed in one block, and serial sections are cut.



Fig. 3.— Adenocarcinoma developed in adenomatous polyp. This polyp has been cut in a manner described in figure 5. Hematoxylin-eosin stain X6.4.

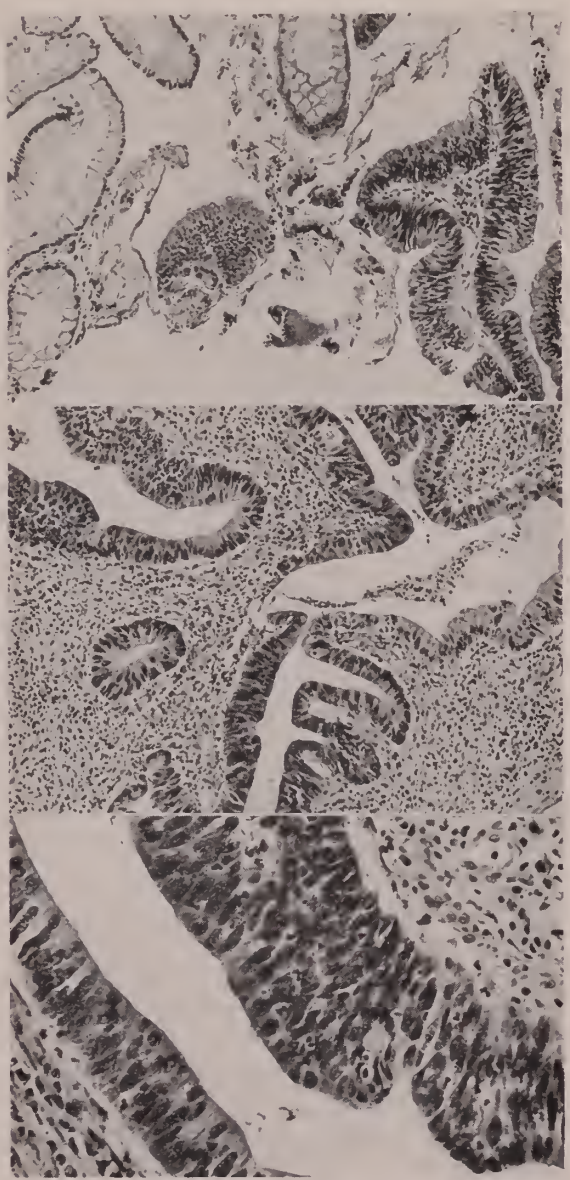


Fig. 4.— Adenocarcinoma developed in an adenomatous polyp. Hematoxyln-eosin stain. (a) View of tip of polyp showing junction of benign and malignant tissue X96. (b) View of adjacent stalk showing malignant glandular formations X96. (c) Higher power of part of (b) showing malignant cells X300.

The Biology of Carcinomatous Polyps

Studies have shown that carcinomatous polyps are of relatively low grade malignancy.[6-8] Thus adenomatous polyps with early carcinoma have been successfully treated by excision of the tumor with the surrounding mucosa. They are therefore not to be regarded in the same category as carcinoma of the large bowel not developed in a polyp.

Method of Pathologic Examination of Adenomatous Polyps

All polyps of the rectum and colon accessible to removal should be removed. It is impossible to tell from the size, shape or general appearance whether the polyp is malignant or not. Ulceration and villous formation in polyps favor a malignant nature. The polyp should be removed with the base wherever possible, without producing electrocoagulative changes in the specimen.

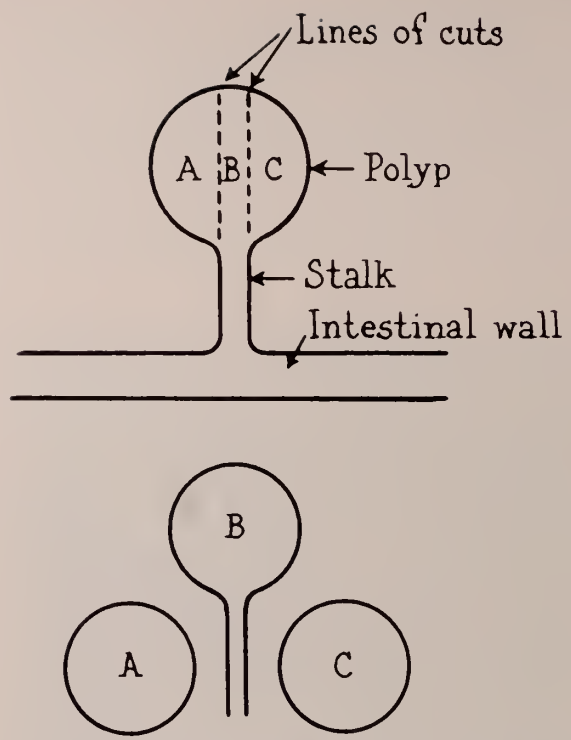


Fig. 5.—Method of sectioning polyp described in text. A and C, sides of polyps. B, part of polyp with stalk.

Every fortieth section is mounted, stained and studied.

This simple technic makes possible the localization of malignant tissue in the tip, on the edges, or in the base. By this method, we believe that we are better able to tell the surgeon: (1) whether there is carcinoma, and (2) how far the carcinoma has progressed.

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Cardiac Defibrillation

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The purpose of this paper is to present 4 cases of ventricular fibrillation and their management. The problem of cardiac arrest has recently received close scrutiny by the medical profession as illustrated by the number of articles on this topic for the past five years. The physicians who have faced the problem of cardiac arrest in the patient on the operating table have realized that ventricular fibrillation can occur before arrest, or during that period when arrest is being converted to a normal rhythm.

In the city of Jacksonville, in the first 8 months of 1953, there were 4 cases of ventricular fibrillation and 7 cases of cardiac arrest. In 2 cases of this series the patient was not in a hospital. The remaining 9 cases were divided among three hospitals. For those physicians who attempt to explain cardiac arrest or ventricular fibrillation solely on the basis of the multiplicity of drugs used for producing anesthesia, it is noteworthy that 1 patient had had no anesthetic; 1 had received less than 10 cc. of Pentothal Sodium in 2.5 per cent solution; 5 were receiving ether; 1 had received rectal Avertin followed by cyclopropane and ether; and 1 had had cyclopropane induction followed by two hours of anesthesia under ether.

It cannot be denied that the physician practicing anesthesiology these days will use a series of drugs to produce ideal operating conditions for the surgeon. The only way to escape this use of a series of drugs is to return to straight ether anesthesia or, as an example, use spinal anesthesia in all operations below the diaphragm. Neither suggestion is plausible, as it is almost impossible to produce an ideal anesthetic situation under

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ether and many patients and some surgeons object to the use of spinal anesthesia. It is my belief that when a close examination is made, in the majority of cases which end in fibrillation or arrest, the one constant factor appears to be anoxia, although this cannot explain all cases. It seems unfair to condemn an anesthetic agent when the possibility of hypoxia and hypercarbia cannot be ruled out in many of these cases.

Ventricular fibrillation resembles cardiac arrest in that the patient's pupils are widely dilated, respiration has ceased or is gasping, there is no blood pressure or pulse, and the blood stream is dark in color. When the chest is opened, the arrested heart is flaccid and still, while the fibrillating heart may vary from an inefficient writhing pump to a heart resembling arrest with but small intermittent twitches signaling the difficulty. For those who are attempting cardiac resuscitation, it is most important to differentiate the two. Their treatment is entirely different, and confusion may prove fatal to the patient.

Management of Ventricular Fibrillation

At present, the treatment for fibrillation is defibrillation by the use of electrical current.[1] There are several good defibrillators now on the market at prices ranging from $100 to $200. Some authors have suggested the use of homemade, inexpensive units. Realizing the average physician's lack of knowledge in the field of electricity, one would do well to keep in mind that if a defibrillator may appear to be expensive, the price tag is moderate indeed for a patient's life and/or the life of the one who is attempting to resuscitate a fibrillating heart. The principle of the defibrillator is simple. House current is modified by the defibrillator so that it passes a current through the heart muscle at 1 to 1.5 amperes, and a varying voltage. The time element may range from .1 second to one second. The current may be modified on some defibrillators from 35 to 135 volts. When one begins to modify the voltage to less than 110, there is a possibility that one may approach a fibrillating dose.

The ideal time period is not known, but it is suggested as between .1 to .5 second. The periods beyond one second intervals may damage the heart muscle. When cardiac arrest or ventricular fibrillation is suspected, the chest is opened immediately. If cardiac arrest is discovered, it is treated by massage, artificial respiration by use of the anesthesia machine, procaine hydrochloride, calcium chloride, and epinephrine hydrochloride. During the resuscitation, fibrillation may develop, or the heart may be in fibrillation when the chest is open. When fibrillation is recognized, cardiac massage should be instituted in an attempt to get fresh blood to the myocardium. In none of the cases of fibrillation to be described was it thought that massage helped pink up the typical dusky myocardium, although other writers state this change is possible. When massage has either produced a more healthy color of the myocardium, or increased the tone of the muscle, or a fruitless attempt has been made for several seconds, the heart is then ready for defibrillation. The current is turned on. A signal light or buzzer will be found on all defibrillators signifying the current is passing through the machine. The timer is set for the desired interval, if the machine has a timer. The voltage meter is set for 110 volts. The saline-soaked electrodes are touched, and either the finger or foot control is pressed. The ammeter will signify a satisfactory flow of current, and on models without an ammeter an impulse and an intensity bulb will signify satisfactory flow. These preliminary checks can be made by surgical personnel while the chest is being opened and the massage begun.

When the defibrillator has been checked, the saline-soaked sterile electrodes are placed on the heart. It should be remembered that the contact surface of the electrodes should touch the heart. It is possible to get the electrode surfaces reversed, and no contact is made. The electrodes are placed opposite each other on the sides of the heart. They must be held firmly against the heart. All personnel leave the table, so that the danger of shock is minimized. The person holding the electrodes should have intact rubber gloves, although the handles of the electrodes are supposedly shock-proof. The foot switch or hand button is pressed. The current passes through the fibrillating heart. The body will jerk convulsively, and the patient may gasp, evidently from stimulation to the diaphragm. If the heart stops fibrillating, the surgical team then faces an arrested heart and is confronted with the task of resuscitating it by massage and supplementary drugs. If fibrillation does not cease, the heart should be massaged again, the electrodes reapplied, and the heart given a series of shocks, five to 10 of .1 second duration at 1 second intervals, as suggested by Wiggers.[2]

There are modifications to this plan of attack. I have applied to the heart 10 cc. of a 1 per cent solution of procaine hydrochloride and have injected 10 cc. of a 1 per cent solution of this drug into the left ventricle before applying the electrodes. The defibrillator may have suction cups on the electrodes. Once the electrodes are in place, the defibrillator will produce negative pressure on these cups holding the electrodes in place. The heart then can be massaged by pressure on the electrode handles. The cases of cardiac arrest are included in this series only to show both the incidence of the accident and the possibility that fibrillation may have occurred before the arrest took place.

Report of Cases

Case 1. — A white man in his early twenties was swimming in a pool. An observer saw him sink and recovered him less than 10 seconds after he disappeared from view. His rescuer stated that the patient was making convulsive motions when he reached the surface. Artificial respiration was instituted by the use of a to-and-fro respirator. It was apparent to those attempting the resuscitation that respiratory exchange was inadequate, and on the advice of a physician, the patient was taken by ambulance to a hospital. The transfer took less than five minutes. No record of pulse or blood pressure was made during this interval.

When the patient reached the hospital, no pulse was present. The chest was opened, and the heart was found in fibrillation. The heart was massaged. Procaine hydrochloride, 10 cc. of a 1 per cent solution, was injected into the left ventricle, and the heart was massaged again. In two minutes the fibrillation stopped. After beating several times, the heart returned to a state of fibrillation. It was realized that defibrillation was necessary and, as there was no defibrillator in the hospital, rather desperate measures were used to return the heart to a normal pace. A diathermy machine was used as an emergency defibrillator. The electrodes of this machine were placed on the heart with no attempt being made at sterile technic. The physician in charge of the case stated that the dosage was uncertain, although he estimated that between 30 and 40 volts were delivered to the heart. This proved ineffective, and then massage was reinstituted.

The nearest defibrillator was brought, the trip requiring 45 minutes. The heart was still fibrillating when the machine arrived. Single stimuli were applied to the heart, three to four times, and normal rhythm was resumed. Once this was established, the heart quickly returned to a state of fibrillation. The shocks were repeated, but it was apparent that the heart could not return to a normal rhythm. It was then decided to use serial shock, which caused the heart to revert to a normal rhythm. The heart retained this rhythm while the chest was being closed. The defibrillation time was approximately 15 to 20 minutes before normal rhythm was restored. Norepinephrine was used to restore the blood pressure to normal, and despite the use of this drug, transfusions of blood and plasma, and intravenous digitoxin, the course was steadily down hill, and the patient died within four hours in profound shock.

The history was noncontributory. He had never been ill. One week prior to the accident, he had complained of "blackouts" while engaged in sports. He was a trained swimmer. It was believed that there was a possibility that a cerebral accident might have occurred despite his youth. A postmortem examination was not granted.

Case 2. — A white boy, aged 3½ years, was under insufflation ether for a mastoidectomy. Details in this case are missing, but difficulty was experienced by the nurse in keeping an open airway because of excess formation of mucus. Forty-five minutes following induction of anesthesia, the pulse disappeared. A diagnosis of cardiac arrest was made. The chest was opened within an estimated five minute period following the diagnosis. The heart was in arrest, and massage was begun. The patient was intubated. The heart responded by fibrillation. Calcium chloride, procaine hydrochloride, and epinephrine hydrochloride were applied to the heart, the dosage not being noted. The heart continued to fibrillate for 45 minutes, during which time massage was being applied. By this time a defibrillator was secured, and a single shock of 110 volts for a .5 second interval threw the heart into arrest. Massage was continued for one-half hour, at which time the patient was declared dead. Normal cardiac rhythm never followed after the arrest had occurred.

Case 3. — A white woman, aged 38, suffering from epilepsy and hypertension, had been followed for several months as an out-patient in an attempt to control thyrotoxicosis. The patient was indifferent as to her own care and the taking of medication. She entered the hospital six weeks prior to surgical therapy and was treated with Propylthiouracil. This drug was increased to a dosage as high as 900 mg. per day. During this period the pulse rate decreased from 122 to 80 and the basal metabolic rate from 60 to 21.

A decision then was reached to perform a thyroidectomy, although the surgical staff regarded the thyroid status not at an optimal basal condition. She received Seconal, grains 3, the night before the operation. On the next day she received scopolamine hydrobromide, 1/200 grain, one and one-half hours preoperatively and Avertin by rectum, 100 mg. per kilogram of body weight, one-half hour prior to the operation. When she entered the operating room, it was noted that she was not completely asleep despite the Avertin basal narcosis, but would move her head on stimulation, although adequate time had been given to allow the drug to produce its maximum effect. The blood pressure was 130 systolic and 85 diastolic; the pulse was 82, strong and regular. During induction with cyclopropane she experienced no laryngeal spasms, nor were there periods of apnea. Ether then was introduced into the circuit, and the cyclopropane was discontinued. This period of induction required 10 minutes.

The patient was painted and draped for thyroidectomy. When the surgeon made the skin incision, he commented that the blood was dark. The mask was removed, the pupils were dilated, and the blood pressure was absent. The chest was opened approximately 30 seconds after the skin incision in the neck had been made. The heart was in violent fibrillation. The airway was open, and intubation was not performed. The lungs expanded well when positive pressure was applied to the rebreathing bag on the anesthesia machine. Ten cubic centimeters of a 1 per cent solution of procaine hydrochloride was injected into the pericardial sac, and 10 cc. was injected into the left ventricle. Massage was begun. The defibrillator was being checked, and within three minutes of opening the chest, the heart received its first defibrillating shock. The voltage started at 85 for the first two shocks at a time interval of .5 second. The voltage was then increased to 110. Between 2:09 p.m. and 2:30 p.m., the heart received 13 separate shocks, the voltage being 110 for the last 12 shocks and the time interval for the first eight .5 second, and the last five .1 second. Massage was continued except when the heart was being shocked. At 2:15 p.m., 10 cc. of a 10 per cent solution of calcium chloride was injected into the left ventricle because the surgeon thought that arrest had temporarily taken place. The heart responded only by filbrillation, and 10 cc. of a 1 per cent solution of procaine hydrochloride was injected into the pericardial sac. Finally, in desperation, the aorta was compressed between the surgeon's fingers. The heart was massaged vigorously, and a series of five shocks was given at .5 second and 1 second intervals. The heart went into arrest and then on

being massaged and being given 10 cc. of a 10 per cent solution of calcium chloride, it responded with regular powerful rhythm 21 minutes after the fibrillation was discovered. The systolic blood pressure was 30, and the diastolic pressure was unobtainable. Four cubic centimeters of a .1 per cent solution of Levophed (Levo-arterenol) was added to 1,000 cc. of a 5 per cent solution of glucose in water, and a slow drip was started. The blood pressure responded dramatically, rising to a level of 150 systolic and 80 diastolic. The patient died approximately four hours later in what appeared to be either recurrence of cardiac arrest or fibrillation.

Case 4. — A woman, aged 30, came to the operating room in shock at 10:30 p.m. with a blood pressure of 90 systolic and 60 diastolic, a pulse rate of 160, and respirations 24. She was conscious and talking, although apprehensive. The diagnosis was ruptured ectopic pregnancy. She had received one blood transfusion prior to arrival in the operating room. At 10 p.m., she had received as medication 100 mg. of Demerol and 1/150 of a grain of atropine. The surgeon was notified of the condition of the patient, and it was the advice of the anesthetist that the operation be withheld temporarily. Because of the bleeding, the surgeon decided to continue. Following induction with a "small amount" of Pentothal Sodium administered by the nurse anesthetist, nitrous oxide and oxygen with ether were introduced into the system. The Pentothal Sodium was discontinued. The pulse became rapid, and the anesthetist stated that she was unable to count the rate accurately. Respiration ceased, and the breathing was assisted with the rebreathing bag. The breathing volume was re-established, and the operation started at 11:05 p.m. The pulse continued to be so rapid that the anesthetist was unable to record it, and no blood pressure was obtained.

The surgeon was notified as to this condition. Despite the apparent grave condition of the patient, the operation was continued rapidly, and a ruptured right fallopian tube was removed and bleeding points ligated. The abdomen was tense. Because of this condition ½ cc. of Flaxedil was given intravenously. This relaxed the abdomen, and the operation was continued. The pulse was not discernible by the anesthetist at any point. The surgeon stated that the heart was beating 40 to 50 beats per minute at this time. This rate was ascertained by palpation of the heart through the diaphragm. Evidently cardiac arrest then occurred, although it is not stated in the notes, because the surgeon performed a thoracotomy and manual massage was instituted on the heart. This produced fibrillation. A defibrillation machine was applied at 12:20 and 12:21 a.m. A 110 volt shock at .5 second intervals was given. Oxygen was being used continuously by pressure on the rebreathing bag. The heart went into arrest, and a normal beat then was produced following further massage. The patient was examined by a member of the medical staff, who gave 4 cc. of Cedilanid (total dose of .8 mg. of lanatoside C) intravenously. The pulse rate decreased. The patient remained unresponsive except that muscular twitchings were noticed. The chest was closed.

The patient was placed in an oxygen tent in the ward. The following morning at 7:30, no improvement in her condition was noted. She lived until 11:55 a.m. that day.

The medical profession with its pharmacologic background has attempted, it appears, to memorize those drugs suggested as supplementary aids to the resuscitation of a failed heart. The real principle has been lost in a welter of ampoules. In the hope of presenting a simple set of rules to follow, I offer the following outline of prophylactic and active measures which I use in teaching the resident staff of the hospital with which I am associated:

Prophylaxis

1. Every case in which anesthesia is required means a potential death on the operating table.
2. Each patient undergoing anesthesia deserves the necessary medical examination and laboratory work which a surgeon or anesthesiologist would request on himself for such a procedure.
3. The person administering the anesthetic is a far more important causative factor than the agent employed when catastrophies occur.
4. The induction period and the termination stage of the anesthesia, generally speaking, are the times of danger for the patient. The remaining segment of the period of anesthesia should be governed by the principle of keeping the patient well oxygenated and in physiologic balance.
5. Each anesthetic must be considered as a compromise between a surgeon and an anesthetist with the patient's life as the stake.

Active Therapy

1. When arrest or fibrillation is honestly suspected, open the chest. Any physician can open the thoracic cage for this emergency. Those who wait for skilled help will fail in resuscitation. Artificial respiration by the use of an anesthesia machine, with or without endotrachial tube, will provide oxygen to the lung.
2. When the heart is in arrest, massage it. Massage means nestling the apex of the heart in the palm of the hand and compressing towards the base. The rate of massage is argumentative. Probably the physiologic rate of 70 is as good as any. Compression on the aorta will fill the heart more effectively than massage without this measure.
3. Drug therapy, coincidental with massage, is a battleground of theories. Procaine hydrochloride on the heart supposedly is used to block the afferent and efferent flow of the autonomic nervous system. The average dose suggested is 10 cc. of a 1 to 2 per cent solution. If this effect is desired, it might be well to suggest the use of Pontocaine Hydrochloride or Xylocaine Hydrochloride, the topical effect of which is far superior to that of procaine. The procaine hydrochloride in the left ventricle is directed into the coronary arteries by the massage. There the procaine hydrochloride again plays its part as a topical anesthetic.

If massage is forcing blood into a near empty aorta, compression of this vessel certainly should produce a better effect, as a back pressure will fill coronary ostia. Again, Xylocaine or Pontocaine might be a better choice. Calcium chloride, 10 cc. of a 10 per cent solution, and epinephrine hydrochloride, 1 cc. of a 1 to 1,000 solution diluted to 10 cc., are used to stimulate a beginning stroke in a flaccid heart. Epinephrine hydrochloride can throw a heart into ventricular fibrillation. It is obvious, then, that drugs are purely supplemental.

4. A fibrillating heart must be defibrillated. Massage is instituted in an attempt to get fresh blood into the myocardium. Following this procedure, a defibrillator is used to produce a single shock or a series of shocks to the heart. Drugs have little place, if any, until the heart has been thrown into arrest. Therapy then is directed merely to resuscitation of an arrested heart.

Summary

A series of 11 cases of cardiac arrest and ventricular fibrillation is reported. The 4 cases of defibrillation are described in detail. The technic of defibrillation is described.

Conclusion

A review of this series leads to one conclusion. For those who are faint of heart in the face of a cardiac catastrophe occurring on the operating table, it is worth remembering that in these 11 cases no chest was opened without just cause. The only error was procrastination.

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Riverside Hospital.

Acute Rheumatic Carditis and Subacute Bacterial Endocarditis in Pregnancy

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MIAMI

The incidence of heart disease in pregnancy is reported as 2 per cent, of which the most frequent form is the chronic rheumatic (90 to 94 per cent), the commonest type being mitral stenosis. The incidence of subacute bacterial endocarditis in pregnancy is apparently less than 0.1 per cent. The incidence of the coexistence of acute rheumatic carditis and subacute bacterial endocarditis in pregnancy has not been reported, but it is noted that both conditions may occur simultaneously in the same case.[1] In young adults with chronic rheumatic heart disease, it is often difficult to distinguish at first whether a new infection is a recurrent rheumatic attack or subacute bacterial endocarditis.

The treatment of acute rheumatic diseases with adrenocorticotropic hormone has produced surprising immediate success in the majority of cases.[2] Although antibiotics, especially penicillin, have assured the control of subacute bacterial endocarditis so that the disease can be arrested in 90 per cent of cases treated, deaths from the incomplete eradication of the infection or from complications still occur in 20 to 30 per cent of the cases. About one half the fatalities are caused by complications; the remainder are due to delay in establishing the diagnosis or inadequate treatment.

Report of Case

Mrs. A. H., a 23 year old white woman, gravida I, first consulted her obstetrician on July 20, 1951. Her last menstrual period had occurred on May 18, and the expected date of confinement was Feb. 22, 1952. The past history included the following: a severe streptococcal throat infection at 9 years of age, rheumatic heart disease at 10 years, tonsillectomy at 11 years, and apparently inactive rheumatic mitral disease with some cardiac enlargement up to 20 years of age. Because of the latter

*Deceased.

diagnosis and the relative absence of significant symptoms, her family physician had advised the patient to marry and bear children. The only symptoms noticed by the patient since her marriage were those of palpitation and occasional precordial discomfort during excitement. Because the patient was poorly nourished and underweight and there was a grade 3 systolic murmur at the apex of the heart, cardiac consultation was advised.

Physical examination revealed the following significant findings: weight 100 pounds, blood pressure 110 systolic and 82 diastolic, pulse 88 and of low volume, temperature 98.6 F., red-streaked throat due to a recent cold, shotty upper cervical glands, a diffuse apical thrust and thrill in the fifth intercostal space on the midclavicular line, a loud blowing midsystolic murmur, grade 3, at the apex, transmitted over the entire precordium, and slight hepatomegaly. Fluoroscopic examination showed mitral configuration of the heart, moderate increase in its transverse diameter and markedly expansile pulsations of a prominent left auricle. There were several tentlike diaphragmatic adhesions bilaterally and slight exaggeration of the bronchial markings. The electrocardiogram showed sinus tachycardia and some myocardial impairment. The diagnosis was that of mitral valvular disease with slight cardiac enlargement, rheumatic in origin. As the patient was two months pregnant and gave no history of heart strain or congestive failure, and as the rheumatic heart condition was considered inactive, she was permitted to undergo a full term pregnancy. Frequent cardiac examinations were advised.

The patient progressed satisfactorily until Oct. 5, 1951, when she complained of afternoon temperatures rising as high as 102.2 F., chills, anorexia, precordial pain, shortness of breath on exertion, joint pains and dyspnea. A cold had developed three weeks previously with frequent bouts of high temperature, sore throat, a nonproductive cough, slight joint swelling and excessive fatigue. She was now 20 to 21 weeks pregnant. Significant physical findings were: temperature 99.6 F., blood pressure 100 systolic and 48 diastolic, pulse 106 and of feeble excursion, pallor, moderate distention and pronounced pulsations of the veins of the neck, congested nose and throat, tender cervical glands, lungs clear, precordial thrust and thrill of considerable degree, P2 greater than A2, loud systolic and diastolic murmurs at the apex of the heart with reduplication of the second sound, moderate hepatomegaly, no hepatic tenderness, no splenomegaly, no petechiae, a tender hazelnut-sized subcutaneous nodule on the forehead, no pedal edema, slightly tender and puffy joint of the left wrist and normal reflexes.

The electrocardiogram showed no essential change. Fluoroscopic examination revealed congestive changes at both hilar areas. The patient was hospitalized the next day with temperature of 100.4 F., pulse 130 and respiration 25. Auscultation revealed a loud harsh systolic murmur continuous with a blowing diastolic murmur at the apex of the heart, moist rales at the bases of both lungs and slight hepatomegaly. Laboratory findings were: blood sedimentation rate 31 corrected, hematocrit reading 27, red blood cell count 2,700,000, hemoglobin 8.6 Gm., white blood cell count 5,550, nonsegmented neutrophils 1, segmented neutrophils 72, lymphocytes 25, monocytes 2, plasma chlorides 620 mg. per hundred cubic centimeters, and nonprotein nitrogen 32 mg. Blood specimens were taken for culture.

A provisional diagnosis of acute rheumatic carditis with mitral and aortic valvulitis or subacute bacterial endocarditis with incipient congestive failure was made. The patient was digitalized, and treatment with salicylates, ACTH and low sodium diet was initiated. Within 48 hours the temperature subsided and joint symptoms disappeared. The electrocardiogram showed no change as compared with the original tracing. The roentgenogram of the chest revealed the following: enlargement of the right ventricle, left auricle and pulmonary artery, increased vascularity in both lung fields; findings consistent with a diagnosis of rheumatic heart disease with mitral valve involvement and pulmonary congestion.

The urine showed a trace of albumin and a specific gravity of 1,006; agglutination tests gave negative results; the blood sedimentation rate became more accelerated, and the red blood count and hemoglobin continued to decrease. To correct the increasing anemia and avoid overloading the heart, six units of red cell suspension were transfused over a period of four days. The intradermal reaction to the toxic filtrate of the hemolytic streptococcus was positive. Blood cultures were reported positive for Streptococcus viridans and alpha streptococcus on October 13; again, they were positive for Str. viridans on October 15. On October 13, ACTH and salicylate therapy was replaced by the administration of penicillin, 300,000 units every three hours, and Combiotic P-S containing 400,000 units of penicillin and 0.5 Gm. of dihydrostreptomycin every 12 hours (total of 3,200,000 units of penicillin and 1 Gm. of dihydrostreptomycin in 24 hours).

On October 15 the electrocardiogram showed T wave alterations and definite evidence of myocardial disease. The laboratory was not equipped to carry out antibody studies for antistreptolysin. Although streptococci were grown on mediums, antibiotic sensitivity tests could not be performed satisfactorily as the organisms were too fastidious to respond to the tests. Because of the questionable accuracy and value of penicillin blood levels, those values were generally unheeded. On October 21 there developed petechiae on the little fingers of both hands, both knees and the left elbow, and the temperature rose to 99.8 F. Penicillin dosage was increased to 1,200,000 units every three hours combined with Combiotic P-S (total 24 hour dosage 10,400,000 units of penicillin and 1 Gm. of dihydrostreptomycin), and maintained for six weeks following the last positive blood culture reported.

The course was uneventful thereafter, and the patient was discharged from the hospital on November 11. At this time the red blood cell count was 3,570,000, white blood cell count 8,250, hemoglobin 10.6 Gm., segmented neutrophils 56, lymphocytes 37 and eosinophils 7. Urinalysis showed a trace of albumin; the specific gravity was 1,009; and rare coarse hyaline casts were present. Antibiotic therapy was continued at home.

The patient was examined again on December 4, Jan. 4, 1952 and February 20. She complained only of occasional palpitation of the heart and tachycardia. She continued to gain weight and remained afebrile. Physical examination showed a grade 3 systolic murmur at the apex of the heart, pulse 100 to 110, blood pressure averaging about 110 systolic and 82 diastolic, and slight hepatomegaly. The lungs were clear on physical and fluoroscopic examination. The heart had assumed a more transverse position with the increasing size of the uterus. The electrocardiogram compared favorably with the original tracing except for notching of the P waves in the second limb lead. The red blood cell count was 4,500,000 and the hemoglobin 10.5 Gm. Seven blood cultures were reported as negative. On February 20, Combiotic P-S was readministered on a 12 hour schedule.

On February 23 the patient was admitted to the hospital with labor pains occurring at 30 minute intervals. Rapid intravenous digitalization was performed on admission. Within 11 hours of the onset of labor, the patient was delivered of a normal healthy infant weighing 7 pounds 12½ ounces. Hyoscine-Demerol sedation and cyclopropane anesthesia were used with the utilization of episiotomy and low forceps during the second stage. She was permitted bathroom privileges on the fourth day postpartum.

The patient had an uneventful puerperium, remained afebrile and had no complaints. She was discharged from the hospital showing the following clinical and laboratory features: pulse 88 and of fair volume, blood pressure 104 systolic and 86 diastolic, systolic murmur at the apex of the heart, grade 3, normal electrocardiographic tracing, CO_2 combining power 48.6 volumes per cent, plasma chlorides 610 mg. per hundred cubic centimeters, blood cultures sterile, red blood cell count 4,150,000, hemoglobin 12.4 Gm., white blood cell count 9,400,

nonsegmented neutrophils 6, segmented neutrophils 83, lymphocytes 10, monocytes 1; urinalysis normal. Penicillin-streptomycin therapy and digitalis maintenance were continued for three weeks postpartum. Examination on March 31 and on April 25 showed a normal temperature, pulse rate, blood pressure and respiratory rate. The last blood culture on March 8 was negative. She had no complaints and stated that the infant was well. The blood sedimentation rate and electrocardiogram were normal, and fluoroscopy of the heart and lungs showed no abnormality other than the mitral configuration observed originally.

Discussion

When first seen, the patient was eight weeks pregnant and showed no evidence of a poor functional state of the heart. Although Hamilton and Thomson[3] stated in 1941 that functional tests are of little or no importance in prognosis in comparison to the structural lesions that are found, other investigators have agreed that the most important factor which contraindicates pregnancy is a poor functional state of the heart. This is best ascertained by careful inquiry of the patient as to the amount of activity she can perform in her daily life without discomfort. The American Heart Association's classification of the functional state in any given heart disease may be applied:

Class I: Patients with a cardiac disorder without limitation of physical activity. Ordinary physical activity causes no discomfort.

Class II: Patients with a cardiac disorder with slight to moderate limitation of physical activity. Ordinary physical activity causes discomfort.

Class III: Patients with a cardiac disorder with moderate to great limitation of physical activity. Less than ordinary physical activity causes discomfort.

Class IV: Patients with a cardiac disorder unable to carry on any physical activity without discomfort.

It has been found that all persons with heart disease who fall into class I or class II almost invariably go through a normal pregnancy and delivery without discomfort. Few, if any, of them die as a result of the heart disease unless the classification changes during pregnancy because of reinfection, excessive strain or other factors. In patients in class III congestive failure often develops during pregnancy, delivery or puerperium and occasionally results in death. Failure invariably develops in those in class IV.[4]

It is likely that acute rheumatic carditis and subacute bacterial endocarditis coexisted in this case. The diagnosis of acute rheumatic carditis was based upon the following features: the presence of chronic rheumatic mitral disease, the degree of anorexia, joint pains with swelling and tenderness, great effort syndrome, dyspnea, loss of weight, precordial pain, pulmonary congestion, fever, the change in the character of the systolic murmur and the appearance of the diastolic murmur, the absence of splenomegaly, the presence of slight congestive failure, the low pulse and blood pressure, the hypochromic anemia, the dilated heart and the intradermal reaction to the toxic filtrate of the hemolytic streptococcus. Admittedly, the intradermal reaction is not conclusive, although it is generally positive in rheumatic involvement and usually negative in subacute bacterial endocarditis.[2] In over 30 per cent of cases of subacute bacterial endocarditis, the spleen is not palpable. Splenomegaly is more apt to occur in rheumatic heart disease with prolonged fever than in subacute bacterial endocarditis; the commonest cause is congestive heart failure.[5]

Numerous investigators have hailed the adrenal hormones, cortisone and ACTH, as the long-sought answer to the control of the acutely active stage of rheumatic fever, especially of the associated carditis.[6,7] A number of observers believe that early treatment materially shortens the duration of rheumatic activity, including carditis. They note, in general, an earlier period of ambulation accompanied by a more rapid subsidence of clinical and laboratory evidence of the disease.[8] Objective and subjective evidences of arthritis disappear as the fever subsides. The clinical and laboratory signs of carditis recede more slowly, but observers agree that the return to quiescence is probably on the whole more rapid than when the hormone therapy is not used. Tachycardia and pericardial friction rubs persist only three to four days. Electrocardiographic changes, such as prolonged P-R intervals or primary T wave changes have returned to normal within two or three weeks. Striking resolution of an acutely dilated heart, as seen by roentgen examination, with concomitant cardiac compensation within five to seven days is not unusual.

Simultaneously with the return to normal of the cardiac mechanism, the close observer will witness strikingly ephemeral auscultatory changes,

as in the diastolic blow of aortic valve incompetency or middiastolic apical rumble, presumably due to relative mitral stenosis in the presence of a dilated ventricle. Such murmurs have disappeared within the space of two weeks, a phenomenon which possibly reflects the rapid subsidence of an acute carditis. A disturbing capacity of the two steroids is that of concealing the presence of an infectious process of a bacterial nature, especially by suppressing fever. The serious consequences of such a phenomenon in the presence of subacute bacterial endocarditis are obvious. It is wise to obtain routine blood cultures for all patients receiving hormone therapy for rheumatic fever or rheumatic heart disease. Therapeutic use of cortisone and ACTH must be tempered with the knowledge that any beneficial response merely represents an undetermined segment of the drug's total potential. With this in mind, one must attempt to strike a balance between the desired effects and the general welfare of the patient.[9]

The dosage of penicillin employed in this case was arbitrary and generous. It has been noted that the sterilization of the blood by antibiotics is not an indication of therapeutic adequacy, nor is the maintenance of a penicillin blood level greater than the in vitro resistance of the infecting organism. Harris and Fishburn[10] believed that penicillin should be part of the treatment regimen in all cases of endocarditis due to a gram-positive coccus, even though in vitro tests may indicate a high degree of resistance. The most reliable evidences of adequate therapy are the normal temperature and pulse, gain in weight, absence of sweats, sense of well-being, normal blood counts and sedimentation rates. Penicillin should be given until this situation has been reached.[11]

Observers have noted that penicillin alone, in heavy dosage, is superior to combinations of the various antibiotics in the treatment of subacute bacterial endocarditis. The most favorably reported combination is that of penicillin and streptomycin, which appears to have a synergistic effect. Penicillin combined with bacitracin, caronamide or Benemid has been used to advantage. Aureomycin is more effective against nonhemolytic streptococci causing subacute bacterial endocarditis. Both Aureomycin and Terramycin are primarily more bacteriostatic than bactericidal. In subacute bacterial endocarditis it seems necessary to kill virtually all the causative organisms to effect a cure, as the host defense is of minimal assistance.[12]

Antibiotic sensitivity tests are often misleading as the sensitivity of the organism in the laboratory usually denotes a bacteriostatic effect. Thus, a sensitivity of 0.3 indicates inhibition of multiplication by 0.3 units of penicillin per cubic centimeter. Organisms remain viable, however, with this concentration of antibiotic and will continue to multiply if transplanted to fresh culture medium or if penicillinase is added.[13] Consequently, a bactericidal antibiotic concentration is desirable, often 40 to 50 times as great as that indicated in vitro. In many cases even this concentration will not control the infection in subacute bacterial endocarditis as the antibiotic in the blood stream may not penetrate through the necrotic debris and fibrin layers enveloping the organisms on the valve cusps. This may explain why, despite apparently successful treatment, 20 to 30 per cent of patients will die as a result of the infection or suffer varying degrees of ill health.

Most relapses occur within three months of the completion of treatment. Deaths from complications, congestive failure or renal insufficiency may be avoided to a great extent by early diagnosis, earlier therapy with massive antibiotic dosage, and the free use of digitalis as soon as any evidence of congestive heart failure appears. The diagnosis of subacute bacterial endocarditis should be provisional and antibiotic therapy started in any case in which the patient has a significant cardiac murmur and an unexplained fever lasting more than one week. Any pregnant woman with a history of rheumatic heart disease should be considered a potential subject for subacute bacterial endocarditis, particularly if the nature of the murmur changes. Cardiovascular stress such as is imposed by incompetent heart valves so greatly increases the susceptibility of endothelial tissues that endocarditis can be produced by the entry of a relatively small number of bacteria into the blood stream.

Every pregnant woman with heart disease has her best interest served only by the close cooperation between the cardiologist and the obstetrician. The consensus is that interruption of the pregnancy in subacute bacterial endocarditis is generally inadvisable as is the use of anticoagulants. The termination of pregnancy after the

twentieth week is dangerous in all cardiac patients. At term, surgical intervention except for purely obstetric reasons should be avoided. The use of anticoagulants is unnecessary and perilous as the valvular lesions in subacute bacterial endocarditis are not of thrombotic character.[14] Pregnant women who have had rheumatic fever with or without evidence of heart disease should be given antibiotics prepartum and postpartum. In subacute bacterial endocarditis the therapy should be continued for at least four weeks from the time of the last positive blood culture to assure as much as possible the complete sterilization of the bacterial vegetations in the heart.

A past history of subacute bacterial endocarditis is no contraindication to pregnancy, but childbearing should be deferred at least six months as it takes three to six months for complete healing of the endocardial lesions.[15] Pregnancy should not alter the treatment of subacute bacterial endocarditis. The advisability of childbearing should be determined by the current cardiac status, and accepted concepts of the management of the underlying heart condition should be followed during the pregnancy, delivery and puerperium. Considerations are the age of the patient, the history of congestive heart failure or auricular fibrillation, general physical condition. anatomic lesion, heart size, electrocardiogram, vital capacity and exercise-tolerance test, except in cases with borderline cardiac reserve. The free use of digitalis in anticipation of the added cardiac burden during pregnancy is generally advisable, as well as the use of antibiotics for any complicating illness.

Intrapartum, the pulse and respiratory rates are valuable guides to the cardiac status. Elevation of the pulse rate over 110 with a respiratory rate over 24 or such elevation of the pulse rate alone during the first stage of labor usually precedes intrapartum or postpartum heart failure by a long enough period to give ample warning of its appearance. At this point rapid and complete digitalization is urgent. The limited cardiac reserve will be conserved if the obstetrician will shorten the second stage of labor by the use of low, low-mid or outlet forceps. In the puerperium early ambulation is advisable if the cardiac status warrants it.

Advice is often sought by young women with heart disease as to the risk they will run by bearing a child. The possibility of a renewed infection needs to be considered on the basis of the past history, and a patient suspected of having suffered infection or reinfection recently should be advised to postpone decision for a year or more. Patients with signs of cardiac enlargement and poor exercise tolerance should be advised that it is unwise to become pregnant. The urgency of desire for a child will sometimes impel women to accept a risk that would not otherwise be taken; the risk being realized, it is for their decision. Women presenting auricular fibrillation run more risk during pregnancy than do those without it. Those with fibrillation, those with large hearts and poor tolerance of exercise, and those with a past history of congestion should be told that the risk is much too grave, and every effort should be made to dissuade them from facing it. When a second pregnancy is in question, experience of the first is one of the most valuable guides to the probable course of the second.[16]

The obstetrician speaks of pregnancy complicated by cardiac involvement, while the cardiologist talks about a cardiac disease complicated by pregnancy. The responsibility a physician assumes in every decision is great. He should not rely upon statistical results alone, but must individualize each case on its own merits after thorough examination and observation. Statistics, however, make the task easier and help in arriving at a final decision. Unfortunately, the attitude of many physicians confronted with these problems depends neither upon the experience of others nor upon the known facts but on single recent personal observations.[17]

Summary

A case of pregnancy complicated by acute rheumatic carditis and subacute bacterial endocarditis is described. The literature concerning these complications is reviewed.

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Tung Nut Poisoning

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The tung nut tree, Aleurites fordii, long has been grown in China as a source of tung oil for commercial use. Its introduction into the United States and the rapid spread of its cultivation in the Southeastern states has created a great new American industry. In the Gulf states area, the cultivation of tung trees has contributed greatly to the diversification of agriculture and to the use of cut-over land, and has been a factor in soil conservation and reclamation.[1]

The tung tree belt of the United States is limited to a narrow strip along the Gulf Coast about 100 miles wide (fig. 1).[2] In this area in 1952, the harvest of tung nuts totaled 120,000 tons.[3] This is a remarkable figure, in view of the fact that the first commercial harvest was not gathered until 1932, at Gainesville, Fla., just 20 years previously.

The mature tung nuts are crushed and their oil expressed for use in the paint industry and allied fields. Tung oil is viscous and dries by polymerization, forming a hard, resistant, waterproof film. Chemically, it is the glyceride of eleostearic acid, an unsaturated fatty acid with three double bonds (9, 11, 13) octadecatrienoic acid.[4]

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Review of the Literature

The toxic nature of tung nuts has been known for a long time.[5-7] Holmes,[8,9] as long ago as 1907, reported toxic symptoms in 5 children who had ingested tung nuts. Palmer[10] described 8 cases of tung nut poisoning, in one of which convulsions occurred.

Erickson and Brown[11] reported a case in a university student who ate one nut after mistaking it for a Brazil nut. An hour later he felt dizzy



Fig. 1.—Tung Tree Belt of United States

and weak and had severe abdominal pain. Violent vomiting and diarrhea soon followed and were persistent. An intense thirst was present, and drinking made vomiting worse. This lasted several hours, after which he felt extremely weak. The next day he had a headache during the morning, but he had no pain.

Carratala[12] described the symptoms of tung nut poisoning in 5 patients, none of whom had eaten more than three of the nuts. They all complained of epigastric pain, generalized colicky abdominal pain, nausea, vomiting of bile, intense thirst and profuse diarrhea. He also noted paresthesias, arm and leg cramps, and exhaustion. Gardner[13] also reported an instance of human ingestion of tung nuts in which violent diarrhea occurred.

Erickson and Brown[11] investigated the toxicity of tung nuts and showed that the decorticated kernels of tung nuts are toxic, causing diarrhea and death in white rats, whether or not the oil was extracted. The extracted oil was not toxic. They found that dry heat (230 F.) destroyed the toxic principle.

Gardner[13] reported that tung oil in large doses is only mildly laxative to rabbits. There was no mucosal lesion at autopsy.

Godden[14] found that tung nuts cause diarrhea in pigs, with microscopic parenchymal damage to the liver and kidneys, and gastritis. He reported the predominating lesion to be gastroenteritis. Rusoff, Mehrhof and McKinney[15] reported that heat plus extraction with solvents rendered tung meal nontoxic. Davis, Mehrhof and McKinney[16] reported that after heat alone tung meal was still toxic as evidenced by retardation of growth in growing chicks. Emmel, Sanders and Swanson[17,18] reported diarrhea in cattle eating tung foliage, gastroenteritis being the lesion found at autopsy.

The nature of the toxic principle(s) in tung nuts has been much discussed. In two communications Emmel[19,20] identified the toxic agent in tung foliage as a saponin. In other articles,[21-23] he gave evidence for the presence in tung nuts of a saponin, as well as a second toxic substance which is alcohol-soluble. A saponin, however, by definition[24] is toxic when administered intravenously, by virtue of its ability to hemolyze red blood cells; it is not toxic when administered orally because it is either not absorbed, or it is hydrolyzed in the gastrointestinal tract. For this reason the saponin of Emmel[19-23] is probably more correctly termed a glycoside.

Henry and Auld[25] suggested that the toxic substance could be a cyanogenetic glycoside. Liu[26] identified a protein which yielded a pentose on hydrolysis and which was therefore also a glycoside (phosphoglucoprotein). After ether extraction of tung nuts for 15 hours in a Soxhlet apparatus, the residue in aqueous solution reduced Fehling's solution weakly before acid hydrolysis and strongly after hydrolysis. The aldose and ketose reactions were positive, but the reaction for pentose was negative after H Cl hydrolysis; however, pentosan was precipitated with phloroglucin. Almost all the sugar in tung kernels is sucrose, as checked by hydrolysis and inversion. The osazone formed after hydrolysis resembled glucosazone. Hakubun[27] found 6.68 per cent nonreducing sugars in tung nuts (pentosans), and Sell and Best[28] identified a nonreducing sugar from tung nuts as sucrose. Any of these compounds on acid hydrolysis could give a positive presumptive test for glycosides. But they could not fill the critical criteria Emmel[19-23] has imposed on his compound.

Carratala[12] attempted without success to identify an alkaloid. It was his opinion that the toxic principle in tung nuts was a toxic antigenic albumin. Lewis[8] and his associates at the University of Michigan also believed that the toxic principle is related to the protein fraction of the nut. Liu[26] identified a water-soluble protein which he named aleurin. He also identified a phosphoglucoprotein (soluble in 0.2 per cent HCl) and an insoluble protein which he called aleumin.

Lee and his group[29-32] at Louisiana State University came to the conclusion that there were two toxic principles. One is apparently a lipid, is unsaturated and is subject to oxidation. The other is sensitive to heat and may be a protein, since this pattern is repeated in other members of the Euphorbiaceae, the castor bean and purge nut.

Bryan,[33] by means of dialysis, isolated a water-soluble protein, an albumin. This protein was toxic when injected into laboratory animals, causing an anaphylactoid reaction and death. He devised a process for detoxifying tung meal (denaturing protein, since aqueous solutions from which proteins were precipitated lost all their toxicity) and tung meal so treated was no longer toxic to animals. He found the albumin to

be antigenic, with greatly increased immunity after injection with the protein. The globulin he isolated was not toxic.

Symptoms and Signs of Tung Nut Poisoning

Previously, 10 cases of tung nut poisoning have been reported.[34] Since then, 31 other cases have been collected, making a total of 41 cases, more than the entire number reported before in the literature. This increase would seem to indicate two things; first, a number of unreported cases are being encountered, and, second, the problem of tung nut poisoning, like the tung nut industry, is growing.

Palmer[10] gave the classic description of tung nut poisoning. He stated: "In a short time after eating the seed, there is a feeling of discomfort, warmth and nausea, followed by vomiting and pain. Depending on the number of seeds eaten, there will be great pain, vomiting, and purging, with cold clammy skin, prostration, gripings, delirium, weak rapid pulse and perhaps death. The quick emetic effect of the poison on the gastric mucosa no doubt accounts for the absence of fatal termination."

This description closely follows the pattern observed in patients,[34] and in animals.[35,36] The ingestion of tung nuts is followed by a symptom-free period of 20 to 30 minutes. Then there is a feeling of gastrointestinal difficulty, as evidenced by nausea, malaise and epigastric pain, followed closely by vomiting. In another few minutes to one hour and a half, diarrhea supervenes. In three to five hours the patient is weak and exhausted, but requires no treatment. Such mild to moderate cases are apparently the result of gastrointestinal allergy to a foreign protein, as evidenced by the following case.

Case 1. — A 44 year old tourist was driving by a tung orchard and thought the nuts resembled butter nuts or Brazil nuts. He ate five nuts or 20 seeds. About 35 minutes after he ate them, he experienced nausea, then vomiting, dizziness, lethargy and diarrhea simultaneously. He vomited lumpy white material and had numerous stools of a loose yellow nature accompanied by violent abdominal cramps and tenesmus. He said he was extremely sleepy, but suffered no thirst or dryness of the mouth until about one hour after he vomited. The temperature was 99 F., the pulse rate 68 and the respiratory rate 14. In the emergency room of the hospital the patient suffered uncontrollable nausea, vomiting and diarrhea. He was not completely oriented. The pupils were widely dilated. He was not cyanotic. The lungs were clear, and respirations were regular. The heart beat was slow and irregular. Reflexes were normal to decreased.

He received no treatment except 7.5 grains of caffeine and was asymptomatic the next morning.

In severe cases, about 25 per cent, an anaphylactoid reaction follows the vomiting closely. The patient is in shock with peripheral circulatory failure, cyanosis, respiratory depression and diminished or absent reflexes. Vomiting and diarrhea are profuse and protracted, and eventual dehydration occurs. This is illustrated by the following case.

Case 2. — J. S., a 3 year old white girl, had a temperature of 99.8 F., pulse rate of 142, and respiratory rate of 40. The child did not know how many tung seeds she ate. She suffered nausea, vomiting and diarrhea of a protracted nature. She also complained of headache, cramping abdominal pain and pain in the lumbar area of the back. Seven and one-half hours after ingesting tung nuts she was seen in the emergency room of the hospital. Cyanosis was present around the lips and ears. The heart beat was rapid, but regular. Respirations were irregular, but the lungs were clear. The pupils were dilated, but reactive. Reflexes were absent. The skin showed great extracellular fluid deficit. The urine possessed a high specific gravity (1.023); there was a 1 plus glycosuria, and white blood cells were present. The yellow mucous stool was negative for occult blood. Methemoglobinemia was ruled out as a possible cause of the cyanosis.

She was treated with magnesium sulfate and mineral oil by mouth, Coramine and caffeine stimulation, oxygen and intravenous fluids (1,000 cc. of 5 per cent glucose in physiologic saline, and 1,000 cc. of 5 per cent glucose in water). She responded to treatment and was discharged the next morning asymptomatic.

The predominating toxicity in tung nut poisoning is gastroenteritis (fig. 2), as is evidenced by the nausea, vomiting, cramps, thirst and diarrhea universally reported on the ingestion of tung nuts. The seriousness that it can attain is evidenced by the water and electrolyte loss accompanying protracted vomiting and diarrhea, the concomitant tachycardia and respiratory changes, and the bowel lesions as seen at autopsy.

Fig. 2. — Symptoms and Signs of Tung Nut Poisoning

I. Mild Poisoning
  A. Gastrointestinal symptoms
    1. Nausea
    2. Vomiting
    3. Diarrhea
    4. Abdominal cramps
    5. Thirst
    6. Tenesmus
  B. Cardiovascular symptoms
    1. Tachycardia
    2. Dehydration
    3. Renal dysfunction
      a. Concentration
      b. Casts
      c. Epithelial cells
      d. Glycosuria

II. Severe Poisoning
  A. Gastrointestinal symptoms as above
  B. Cardiovascular symptoms as above
  C. Central nervous system symptoms
    1. Pyrexia
    2. Tachypnea
    3. Irregular respirations
    4. Cyanosis
    5. Mydriasis
    6. Depressed reflexes
    7. Paresthesia

The central nervous system is also attacked either directly or indirectly as evidenced by cyanosis, paresthesia, mydriasis, irregular respirations, reflex changes, fever, and convulsions. The kidneys suffer temporary damage, at least, resulting in glycosuria, crystalluria and casts.

Chemical Studies of Tung Nuts

Because the symptoms and signs of tung nut poisoning simulate atropine poisoning, attempts were made to isolate an alkaloid from tung nuts. Cold infusions of tung nut meal (whole tung nuts ground in a food chopper) were made with dilute sulfuric acid, acetone, ether and ethyl alcohol. These infusions failed to give alkaloidal reactions with standard alkaloidal reagents (phosphomolybdic acid, picric acid, potassium mercuric iodide); and the acid extract, when neutralized with sodium hydroxide, yielded no precipitate. These findings were interpreted as evidence that no alkaloid exists in tung nuts, as previously reported by Carratala.[12]

Studies of the reducing substances in tung meal, before and after hydrochloric acid hydrolysis, showed a substantial increase after hydrolysis. This was interpreted as indicating there is a significant quantity of glycoside present, as suggested by Emmel.[19-23] Extension of these studies is recorded in table 1.

The presence of protein was investigated in the following manner. Finely ground tung meal was extracted with water for 24 hours and filtered. The filtrate was found to be positive for albumin by standard tests (heat plus acetic acid, Robert's reagent, sulfosalicylic acid, trichloracetic acid). Protein reactions were positive as evidenced by the biuret reaction, the xanthoproteic reaction and precipitation by silver nitrate after alkalinization. Attempts to separate albumin and globulin fractions by means of ammonium sulfate precipitation were unsuccessful. Quantitative protein studies are recorded in table 1.

Table 1. — Reducing Substances and Digestible Protein in Tung Nuts

	Meal Gm.	Solvent cc.	NPN Before Trypsin	NPN After Trypsin	Digested Protein Gm./100 Gm.
Protein Studies	126.8	Water 550 cc.	30.5	67	1.27
DOG A	Meal plus trypsin 63 Gm.	No nausea, vomiting or diarrhea over four hour period			
DOG B	Meal plus trypsin 64 Gm.	No nausea, vomiting or diarrhea over four hour period			
Glycoside Studies	Meal Gm.	Solvent	Reducing Substance After Alcohol, mg./100 cc.	Reducing Substance After H_2O, mg./100 cc.	Reducing Substance Gm./100 Gm. meal
	130.5	1 Alcohol 350 cc. 2 H_2O 400 cc.	2400	1500	6.4
	1:30	2:30	3:30	4:30	5:30
DOG C	Fed 65.0 Gm.	No effect, normal stool	Vomited, ill-tempered	Vomited, normal temper	Normal
DOG D	Fed 65.5 Gm.	Light stool	Vomited	Sickly, depressed	Still sick, more responsive

Table 2. — Toxicity of Treated Tung Nuts in Rats

GROUP	DIET	TOXICITY	WATER CONSUMPTION			
			24 HRS.	36 HRS.	48 HRS.	AVERAGE
Group I 5 rats	Normal control	0	150 cc.	300 cc.	450 cc.	90 cc.
Group II 5 rats	Untreated tung meal 20% Diet 80%	+++	300	550	700	140
Group III 5 rats	Tung meal plus 1/12 N HCl 20% Diet 80%	++	300	600	750	150
Group IV 5 rats	Tung meal plus 10% HAc 20% Diet 80%	++	300	550	700	140
Group V 5 rats	Tung meal plus $MgSO_4$ 20% Diet 80%	+	300	525	675	135
Group VI 4 rats	Tung meal	++++	300	600	875	219

Animal Experiments

Attempts were made to reproduce the symptoms of tung nut poisoning in rabbits, by using first an extract of ground tung meal in which atropine is soluble, and then using tung oil. Both were unsuccessful.

Since it is the opinion of some investigators[8,12,29,30,33,37] that the toxic material in tung nuts is a protein, tung meal was treated with several agents which denature protein (hydrochloric acid, acetic acid, and magnesium sulfate) and was fed to white rats. The results are recorded in table 2. In each of the five groups eating tung meal, evidence of toxicity was noted within 90 minutes. This was indicated by increased water consumption, increased moist to diarrheal stools, lethargy, sluggishness and decreased response to stimulus (table 2). The animals eating meal containing denatured protein fared better than the rest.

This experiment was modified in a similar experiment with dogs, in an unsuccessful effort to establish pilocarpine as an antidote for tung nut poisoning. These results are recorded in table 3. The dogs fed tung meal soaked in magnesium sulfate solution fared much better than the other animals, and pilocarpine made all animals in whom it was used sicker than the others.

In a third experiment, one group of dogs was fed tung meal after room temperature incubation with trypsin;* and another group was fed tung meal after extraction first with ethyl alcohol and then with water. This was done to extract the glycoside. The results are recorded in table 1; destroying the peptide linkage by means of a proteolytic enzyme seems to destroy the toxicity of tung nuts completely.

This experiment was repeated except that the filtrate was treated with trypsin to determine if a glycoprotein was present and to compare the relative efficiency of alcohol and water as toxin extractors. The results are recorded in table 4. The toxic protein in tung nuts is soluble in water and is presumably not a glycoprotein. Tung meal extracted with alcohol is less toxic than untreated tung meal; and meal extracted with alcohol and water is apparently still less toxic.

Discussion

Various investigators[8,11,13] have endeavored to incriminate tung oil as the toxic material in tung nuts. None was able to produce more than a transitory, mild diarrhea and all agreed it is not toxic. Our results agree with this conclusion. Lee, [29,30] however, believed there is a toxic lipid

*Supplied by Mr. K. E. Harper of Armour Laboratories.

present which is unsaturated and is subject to oxidation. These criteria are met by eleostearic acid, the fatty acid hydrolysate of tung oil; but, since tung oil is not toxic, it could hardly be incriminated. There almost certainly is not a toxic alkaloid present in tung nuts. The tung tree (Aleurites fordii) is a member of the spurge family or Euphorbiaceae. Other members of this same family are the castor tree (Ricinus communis) and the croton tree (Cascarilla tiglium), both of which produce toxic beans, containing the proteins ricin and crotonallin respectively. It seems reasonable that the tung tree should also produce a toxic protein (aleurin). Carratala,[12] Lee[29,30] and Lewis[8] all believed that the toxic material is a protein. This conclusion was borne out by Erickson and Brown[11] and Rusoff, Mehrhof and McKinney,[15] who reported that moderate heat destroys the toxic principle in tung nuts. Later, however, Davis, Mehrhof and McKinney[16] denied this, in a study of chronic toxicity in growing chicks. Bryan[33] seems to have proved it beyond reasonable doubt by isolating a toxic albumin. Certainly our data indicate (1) that the toxicity of tung nuts is decreased by exposure of tung meal to compounds which denature protein, (2) that the toxic material is water-soluble and (3) that it is destroyed by enzyme digestion with trypsin. All these would indicate that one toxic material, at least, in tung nuts is a protein. A glycoside, however, is present in tung nuts and it may also be toxic. But glycosides are relatively insensitive to heat, are both alcohol-soluble and water-soluble and should not be destroyed by trypsin digestion. A glycoprotein presumably is not present in tung nuts.

Further studies are being planned on the glycoside fractions in tung nuts.

Treatment

Tung nuts look good. The whole ripe nut looks like a large walnut and the unhulled seed is similar to a Brazil nut. Too, tung nuts taste good. The mature nut fresh from the tree has a sweetish taste like a chestnut, while the older, stored nut has a pleasant toasted almond flavor which is spoiled by the rancid after-taste which tung oil leaves in the mouth. Tung nuts are toxic, and the cultivation of the tung tree for commercial and shade tree purposes is spreading. Because of these facts, especially the use of tung trees in urban areas where children have access to the nuts, tung nut poisoning is apt to be more and more common.

The major symptoms of tung nut poisoning are caused by a toxic protein, an albumin.[33] Treatment, then, is symptomatic, as it is for any food poisoning due to a foreign protein.

Magnesium sulfate seems to denature the protein.[34-36] Whether this change is accomplished

Table 3. — Effect of Pilocarpine on Tung Nut Poisoning

GROUP	ANIMAL	MEDICATION	TIME FOR SICKNESS IN MINUTES	TOXICITY
A	1	Tung nuts	30	+++
	2	Tung nuts	20	+++
B	3	Tung nuts plus pilocarpine IM	12	++++
	4		15	++++
C	5	Tung nuts treated with $MgSO_4$	50	+
	6		45	+ without pilocarpine ++++ with pilocarpine

by its cathartic action, by osmotic dilution of the offending protein, or by salting out of the protein by the sulfate ion is not known.

Concomitant with the use of magnesium sulfate, fluid and electrolyte replacement therapy is indicated, especially for those severely poisoned patients suffering from anaphylactoid reactions and potassium deficiency. Central nervous system stimulants and oxygen should also be used when indicated. In an extreme case, it is conceivable that intravenous corticotropin might be used.

Table 4. — Alcohol and Water Extracted Tung Meal in Dogs

	Alcohol	Filtrate	Water	Filtrate		
	NPN Mgs. %	Reducing Substance Mgs. %	NPN	Reducing Substances		
Before Trypsin	30	110	103	150		
After Trypsin	25	50	140	128		
	Meal After Alcohol Extraction		Meal After Alcohol and Water Extraction		Untreated Tung Meal	Control Fed Animals
Dog 1	Vomited 77 min. Diarrhea 150 min.		Sick 110 min. Vomited 190 min. No diarrhea		Vomited 30 min. Diarrhea 110 min.	No illness
Dog 2	Vomited 30 min. No diarrhea		No vomiting No diarrhea		Vomited 30 min. Diarrhea 115 min.	No illness

Summary

Tung nut poisoning is discussed and the literature reviewed. The primary toxic agent in tung nuts is a foreign protein, an albumin causing gastrointestinal symptoms (nausea, vomiting, diarrhea) in mild cases, with shock and respiratory depression in severe cases. Tung oil is not toxic. A glycoside is present which may or may not be toxic. There is no alkaloid present.

The treatment of tung nut poisoning consists of magnesium sulfate by mouth, parenteral fluid and electrolyte therapy, central nervous stimulants when necessary, and oxygen.

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ABSTRACTS OF MEDICAL ARTICLES

Coexistent Pulmonary Tuberculosis and Systemic Blastomycosis: Report of a Case Successfully Treated with Streptomycin, Para-Aminosalicylic Acid, and Stilbamidine. By Thomas C. Black and Henry M. Wilson. Am. Rev. Tuberc. 68:615-621 (Oct.) 1953.

A case is reported in which a young white man, while convalescing from pulmonary tuberculosis, was found to have systemic North American blastomycosis. The coexistence of these two diseases occurs rarely; the authors were able to find only 2 cases reported in the literature. Systemic infection with Blastomyces dermatitides, the fungus which causes North American blastomycosis, has a grave prognosis with a mortality rate of approximately 85 per cent. Treatment of this disease has been far less satisfactory than that of tuberculosis.

In the case here described the patient was successfully treated with streptomycin-PAS and stilbamidine, with the patient remaining well 16 months after treatment. Since stilbamidine is a highly toxic agent if exposed to light after being put up in solution, the authors observe that with precaution against exposure to sunlight, the only chronic toxic effect has been confined to a unique neuropathy of obscure mechanism consisting of paresthesia, anesthesia, hypalgesia, and numbness, usually confined to the face. Their patient experienced this neuropathy in the face in mild form; it disappeared after several months had elapsed.

The Bacteriologic Diagnosis of Enteric Infections. By Albert V. Hardy, M.D.; Richard P. Mason, Colonel, MC, USA; David Hamerick, Ensign, MSC, USN; and Roland B. Mitchell, Ph.D. Armed Forces Med. J. 4:541-553 (April) 1953.

Since enteric infections are a continuing and often a major problem in the Armed Forces, their bacteriologic diagnosis is of great importance in the Armed Forces laboratories. The authors point out that the best diagnostic facilities for these infections are those readily available, capable of handling large numbers of examinations and able to provide dependable findings as quickly as possible. In the interest of effective control, the initial work, therefore, must be done in the smaller laboratories close to the problem rather than the usually far removed large central diagnostic laboratories. This work falls necessarily to technicians since expert bacteriologists are rarely available in smaller laboratories.

Accordingly, this article presents an outline of technics designed to serve as a practical guide for studies in the field, for smaller laboratories, and for workers of more limited experience with these organisms. The technics described are believed best for others than widely experienced bacteriologists and were evolved in part through comparative studies in a Public Health Laboratory and, in part, through experience in the study and control of an extensive outbreak of enteric infections in Korea.

Intrarenal Gas: Report of Case and Review of Literature. By G. Ashby Winstead. J. Urol. 68:423-429 (Aug.) 1952.

Although the paucity of case reports in the literature indicates that gas bacillus infection of the kidney occurs infrequently, its serious import, when it does occur, makes early recognition and treatment important. A case of silent intrarenal gas bacillus infection with destruction of the kidney complicating a vaginal ureterolithotomy performed 12 years previously is described. Unfortunately, the gas-forming bacillus was not isolated. The intrarenal gas shadow was vividly demonstrated by roentgen studies.

In his review of the literature the author noted that gas bacillus infections of the kidney complicated either renal or ureteral surgery in the majority of instances. In table form he summarizes the 30 cases reported prior to presentation of his case.

The Physician, His Wife, and Government. By R. B. Chrisman Jr., M.D. Texas State J. Med. 49:366-368 (June) 1953.

Addressing the Texas Medical Association in April 1953, Dr. Chrisman discusses federal trends and pays tribute to the A.M.A. Washington office. On the ground that "politics is citizenship in action," he then graphically portrays the role of the physician and of his wife as citizens, emphasizing the role of women as "born crusaders" and declaring that "our participation in the political and civic affairs of our individual communities is the greatest foundation for successful citizenship." As qualifications of good citizens he specifies registering and voting, serving the local community, and giving to all worth while campaigns.

"Yes, doctors are citizens too!" he declares. "Just as citizenship begins as an obligation, it ends as a reward. To the degree that all our responsibilities as citizens are fulfilled depends the success of our personal and professional life. Each in his own way, according to his conception of duty, must practice the best citizenship he knows and the best medicine he knows.

"In conclusion, let us not take for granted that freedom of the individual will continue without effort, but, rather, pledge ourselves today, tomorrow, and for the generations to come 'to work for the freedom that works for us'."

Indications for Segmental Resection and Local Excision in Pulmonary Surgery. By Hawley H. Seiler, M.D. Am. Surgeon 19:654-663 (July) 1953.

The author stresses the increasingly important role of segmental resection and local excision in the surgical treatment of pulmonary diseases. They are well established methods in the treatment of bronchiectasis and tuberculosis, he points out, and are also often indicated in the treatment of benign tumors, chronic lung abscess, cysts, blebs and bullae, mycotic diseases, metastatic tumors, arteriovenous fistulas, and certain indeterminate and miscellaneous conditions. He discusses the instances in which these procedures are usually considered applicable in these conditions.

In summary, he observes that it is incumbent upon the thoracic surgeon to remove with the disease as little normal, functioning lung tissue as possible, though not at the expense of the disease process. Such a procedure is possible in many of the benign conditions which affect the lung, but should not be considered in primary bronchogenic carcinoma. Many patients who possibly would not tolerate more extensive removal of lung tissue may now be subjected to surgery of this type.

Acute Cholecystitis: Optimum Time for Surgical Intervention, Based on the Physiopathologic Picture. By Stanley Frehling, M.D., F.I.C.S. J. Internat. Coll. Surgeons 20:204-206 (Aug.) 1953.

Since the question of what is meant by early surgical intervention in acute cholecystitis remains controversial, the author turns to a review of the physiopathologic background of this disease, which is reasonably clear, as a basis for deciding an optimum time for surgical intervention. After consideration of the pathologic process of acute cholecystitis, he concludes that the optimum time for surgical intervention is after the patient has been rehydrated and the electrolyte balance, plasma and blood cells have been restored, but before necrosis of the gallbladder has progressed to the point of perforation and the associated complications. He observes that one may be limited to cholecystostomy for the "poor risk" patient with suppuration who cannot be better prepared for cholecystectomy.

Optimum Morale: Its Importance in an Army General Hospital. A Suggested Method of Study. By J. A. Rudolph, M.D. Mil. Surgeon 113:103-108 (Aug.) 1953.

Along with the rise and fall of the physical condition of the hospitalized soldier there goes a rising and falling psychic condition, frequently designated as morale, state of mind, or degree of adjustment. The author contends that this element of his total personality is at least as perceptible and subject to recording as his physical condition and makes a plea for employment, by all the medical and administrative officers of the hospital, of a technic by which the patient's psychologic condition would be carefully observed at all stages of hospitalization. A chart, based on observation of 300 cases over a two year period, is presented as a means to this end. It shows a downward tendency for the first few days, followed by a sharp rise for some 18 days, but after the thirtieth day the decline in morale is rapid. A more definite and thorough psychosomatic approach in the handling of patients is advocated, and discharge or return to duty of most patients at an earlier stage of hospitalization, before morale has fallen to a point where they are no longer good soldiers or even good citizens, is suggested.

Cerebral Circulation and Metabolism in Pulmonary Emphysema and Fibrosis with Observations on the Effects of Mild Exercise. By P. Scheinberg, I. Blackburn, M. Saslaw, M. Rich, and G. Baum. J. Clin. Investigation 32:720-728 (Aug.) 1953.

Chronic pulmonary disease, particularly emphysema and fibrosis, may result in variable alterations in blood oxygen and carbon dioxide tensions, depending upon the severity of the disease. In this study, cerebral blood flow, oxygen consumption, and vascular resistance were measured in 22 patients with chronic pulmonary disease of moderate functional severity and were compared with like measurements in a group of normal controls of the same average age. The effects of mild exercise were studied in 12 of the patients.

There was no significant difference in cerebral blood flow as measured by the intermittent sampling technic in 13 of these subjects as compared to the continuous sampling technic in the remaining 9 subjects. Mean values for cerebral blood flow, cerebral A-V O_2 difference, cerebral oxygen consumption, and cerebral vascular resistance did not differ significantly from these values for the normal control subjects. The correlation between cerebral blood flow and arterial $_pCO_2$ was good, whereas no correlation was noted between cerebral blood flow and arterial $_pO_2$ or per cent arterial O_2 saturation. The effects of exercise on cerebral metabolic functions in these patients were variable and without a significant trend. A reduction in arterial $_pH$ during exercise did not influence cerebral blood flow.

These studies re-emphasize the important relationship between arterial $_pCO_2$ and cerebral blood flow and demonstrate the relative unimportance of the clinical and spirometric severity classification on cerebral blood flow in chronic pulmonary disease.

Prolonged Labor, Clinical Evaluation. By John R. McCain, M.D., Clarence L. Anderson, M.D., William M. Lester, M.D., and Joseph W. Pilkington, M.D. J. A. M. A. 153:695-699 (Oct. 24) 1953.

The 158 prolonged labors occurring among 19,159 deliveries under the supervision of the department of obstetrics and gynecology of Emory University at Grady Memorial Hospital between July 1, 1948, and Dec. 31, 1951, are evaluated clinically. The incidence of prolonged labor was 0.8 per cent. All of the mothers lived, but 33 of the infants died, an infant mortality rate of 20.9 per cent.

Primary uterine inertia was present in the labor of 145 patients and was the only etiologic factor recognized clinically in 121, or 77 per cent, of the cases. Because of the high incidence, this paper becomes, in effect, a clinical evaluation of primary uterine inertia as a cause of prolonged labor. In 31 cases fetopelvic disproportion was present, with 12, or 38.7 per cent, of infants lost. The infant mortality was 50 per cent in 12 cases of breech presentation, in those cases in which the babies weighed 4,000 Gm. or more, and also in those in which the patient was over 30 years of age. In 85 per cent of the prolonged labors the patients were primiparas. Fetopelvic disproportion and/or presentations of the infant other than cephalic occurred in 65 per cent of the multiparas.

Progress became arrested in 75 per cent of the cases before labor had lasted 24 hours. The cervix was dilated not more than 4 cm. in 100

patients at the time that the arrest of progress occurred. If progress became arrested, with the membranes ruptured and the presenting part still unengaged, over 50 per cent of the infants did not survive. The most effective treatment after the arrest of progress in patients with the amniotic membrane still intact was artificial rupture of the membranes. If the patients did not deliver within eight hours after the rupture of the membranes and the use of pituitary extract (unless contraindicated), the results obtained by vaginal deliveries were found to be unsuccessful in half of the cases. The 43 patients in labor over 48 hours lost 40 per cent of their babies. The underlying causes of death for the infants were predominantly intrapartum fever or operative delivery. The patients who had had fever for more than 36 hours before delivery lost 81.2 per cent of the infants. Elevated temperatures during labor or operative procedures at delivery occurred in all except two of the cases in which the infant died after 48 hours of labor.

The later pregnancies of the women whose prolonged labor had been caused by uterine inertia alone were delivered spontaneously, after short labors, with excellent results for the infant. In the patients with prolonged labor complicated by fetopelvic disproportion, over 50 per cent of later infants were delivered by cesarean section.

Prolapsing Ureterocele. By Louis M. Orr and (by invitation) James B. Glanton. Tr. Am. A. Genito-Urin. Surgeons 44:204-210, 1952.

First described as early as 1835, ureterocele, or intravesical cyst of the ureter, is defined as an intravesical ballooning of the distal end of the ureter with involvement of all the component layers of the ureteral wall although that of the middle coat is usually minimal. The several etiologic theories and the classification, symptomatology and treatment of this relatively common lesion are discussed. Prolapsing ureterocele, however, is not common and, in addition to the symptoms and complications associated with simple ureterocele, is further complicated by producing varying degrees of vesical neck obstruction. Gangrenous changes of the prolapsed mass must also be considered. In differentiating prolapsed ureterocele from prolapse of the ureter it is only necessary to observe that in ureterocele there is a definite ballooning out of the smooth mucosal surface, whereas in urethral prolapse there is merely an eversion of the mucosa.

In the case reported, prolapsing ureterocele occurred in a white female infant aged 11 months. The authors list 46 cases collected from the literature and believe their case is the forty-seventh to be recorded. Surgical correction was instituted in the form of an ureteronephrectomy and extraurethral excision of the ureterocele. The pathologic examination of the specimen confirmed the initial diagnosis of prolapsing ureterocele with a resultant hydroureteronephrosis, above which was a double ureter with a common ureteral orifice. The smaller accessory ureter did not communicate with the renal pelvis, but ended blindly at the base of a congenital renal cyst. Complete continence of urine has been maintained, and the patient has remained well.

Treatment of Perennial Rhinitis. By James H. Putman, M.D. South. M. J. 46:1134-1138 (Nov.) 1953.

Allergic rhinitis, the commonest respiratory allergic disease encountered, is discussed from the standpoint of the clinical picture, causative factors, diagnosis, treatment, and symptomatic measures. Although it is important in its resulting consequences and the best time for diagnosis and treatment is in the early stage, nevertheless for various reasons this condition is neglected, long unrecognized and poorly treated. The author is of the opinion that good results can be anticipated if thorough investigation and treatment along allergic lines are carried out.

Subacute Disseminated Lupus Erythematosus in the Negro Male; Report of a Case. By Warren Lindau, M.D. South. M. J. 46:1099-1102 (Nov.) 1953.

A case of disseminated lupus erythematosus occurring in a Negro man is reported and discussed. The diagnosis was made clinically and corroborated by an L. E. test giving positive results. Findings at autopsy confirmed the diagnosis. The disease was of the subacute type, the patient surviving for three years after the onset of the illness. The author found only 4 cases of disseminated lupus erythematosus in a Negro male reported in the literature, making his case the fifth to be recorded and also the first of the subacute form in such a patient, for in the other 4 cases the acute form of the disease was present.

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NOTICE

This May Journal carries the new officers and committeemen with the exception of the president-elect, vice presidents, secretary-treasurer and editor of The Journal. The names of these officers are omitted because the May Journal went to press before the election of officers by the House of Delegates, April 28.

All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1954.

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSOCIATION

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All new officers will be listed in your June Journal, as will the personnel of The Journal staff for 1954.

Administration Reinsurance Plan

On March 11, bills were introduced in the House and Senate to carry out the plan of the present administration for reinsuring prepaid health insurance plans. The program, as explained by the Department of Health, Education, and Welfare has the following objectives: "The program would not reinsure . . . a particular policyholder nor . . . a carrier as such. It would protect the carrier against bad experience in the aggregate under a particular reinsurance plan. Only abnormal losses and those in excess of anticipations would be reinsured. . . The carrier would share in paying these abnormal losses (U. S. share limited to 75%). . . The program is designed to encourage carriers to experiment more broadly and rapidly. . . Success would depend entirely on voluntary action by (carriers)."

A federal appropriation of $25,000,000 would start the program, and it is expected that the fund would be made self-sustaining within five years by scaling premiums to match expenses, with the government advance to be repaid. The federal obligation would not extend beyond the money in the reinsurance fund, or in separate funds if they are established.

The responsibility for administration would rest with the Secretary of Health, Education, and Welfare, who would also fix rates of reinsurance and could cancel contracts for cause. State insurance authorities would be used to the maximum extent.

With the approval of the Secretary, private insurance companies, voluntary nonprofit associations such as Blue Cross and Blue Shield, and other voluntary groups could participate by complying with specified conditions and standards. The Secretary would establish terms, conditions and requirements for types of plans. Objectives given major consideration would be: extension of coverage to persons not now protected, extension to new geographic areas and provision of benefits and services not now readily available. To win approval, plans would have to be (a) financially

sound, (b) operating according to state law, and (c) worthy of public confidence. The Secretary would specify minimum benefits and waiting periods, and set up safeguards against undue exclusions based on such factors as pre-existing conditions and specific illnesses. Plans of a given kind or type could be reinsured only if reinsurance, on comparable terms and conditions, were not available from private sources.

The Secretary would appoint a National Advisory Council on Health Service to serve in an advisory capacity and make recommendations. Four of its 12 members would have to be experienced in the administration of health plans. In addition, the Department would maintain a technical advisory and informational service to assist health plans without cost. The information service would conduct studies and collect and distribute information on the organizational, actuarial and other problems of health insurance.

The House committee began hearings on March 24 with Secretary Hobby the first to testify. She stated that although the Administration believes the program holds great promise, it has the following limitations: (1) it can only help those who can and are willing to include health insurance premiums as a necessary part of the budget and those covered by employer-maintained plans; (2) it "may not immediately" solve the problem of coverage for those who are now aged or chronically ill, and (3) success of the plan depends on willingness of carriers to make use of the plan and to assume new and broader risks. Mrs. Hobby said reinsurance to plans that furnish their own medical care could be offered, provided they place control over the manner in which medicine and dentistry are practiced solely in licensed members of the profession. She also stressed that (1) the bill forbids exercise of any supervisory or regulatory control over any carrier, hospital or other facility, except as specified in the act, and (2) the program would be wholly voluntary and no individual plan would be reinsured if it could be reinsured privately.

On April 1 the American Medical Association reached a policy decision on this bill. Its position was outlined in testimony before the House Interstate and Foreign Commerce Committee on April 5 by Dr. David B. Allman, a trustee and chairman of its committee on legislation. "A federal reinsurance system," he said, "such as proposed by the bill could not be expected to achieve the objectives set forth in this legislation. In addition, the measure as drawn would place extensive regulatory power in the Secretary of the Department of Health, Education and Welfare. The concentration and delegation of such potential power and control over a vital branch of American industry in a department of the Executive Branch of the government without clear and convincing evidence of need is extremely difficult to justify.

"'Let me reiterate that we believe the sponsors of this proposal are deserving of commendation in attempting to spread voluntary health insurance through private initiative. Nevertheless it is the belief of the American Medical Association that the bill will not fulfill its intended purpose and may, in fact, inhibit the satisfactory progress which is now being made by voluntary insurance companies. For these reasons it is the recommendation of the Association that this bill should not be reported favorably by this Committee."

The United States Chamber of Commerce and national spokesmen for the insurance industry took about the same position.

Physicians' Viewpoints on Medical Problems

To get the general viewpoints on some of the key medical issues confronting the medical profession today, a questionnaire was distributed to physicians attending six regional legislative conferences held in San Francisco, Denver, Dallas, Atlanta, Chicago and New York early this year. The Committee on Legislation of the American Medical Association, sponsor of these conferences, received 229 responses to the queries.

One question was: Do you favor or are you opposed to the extension of social security to include physicians? Eighty per cent were opposed, and 20 per cent favored this extension.

Another question asked if they favored or opposed the A. M. A. position regarding veterans care for non-service-connected disabilities. Eighty-five per cent favored it, and 15 per cent were opposed.

Still another question asked whether they favored or opposed the Bricker amendment. In this instance, 79 per cent favored it, and 21 per cent were opposed.

The 80 per cent opposition to the first question was bettered in a poll of Arkansas physicians. Spurred by a New Jersey Congressman's statement that rank and file doctors favor inclusion under social security despite A. M. A. opposition to the proposal, Paul C. Schaefer, executive secretary of the Arkansas Medical Society set out to learn if the Congressman knew what he was saying. Nearly three fourths of the 1,230 physicians in Arkansas replied to his questionnaire, and 85 per cent of them opposed doctors' inclusion under social security. The poll, Mr. Schaefer said, not only proved that doctors want no part of this type of compulsory "insurance" from the government, but it also made conscious of the pending legislation many who previously had given no consideration to the bill.

In Florida, the Committee on Legislation and Public Policy of the Florida Medical Association, under the chairmanship of Dr. H. Phillip Hampton, sent out a questionnaire to 2,330 members of the Association on the matter of extension of social security to include physicians and received 1,585 replies, a 68 per cent return. Eighty-two per cent were opposed to the extension, 64 per cent unconditionally and 18 per cent unless the $75 minimum on maximum earnings to receive benefits was substantially raised or eliminated. Eighteen per cent favored the measure. A particularly large number wrote in their preference for the Jenkins-Keogh type of legislation, which would permit self-employed persons to defer income tax payments on a portion of their earnings to be paid into restricted annuity plans.

With regard to the Bricker plan, it is noteworthy at this writing that the proposed constitutional amendment limiting the power of the President to make international agreements may be reconsidered, following its one vote failure to pass the Senate on February 26. On that date the Senate voted 60 to 31 to pass an amendment proposed by Senator George (D., Ga.) as a substitute for the amendment sponsored by Senator Bricker (R., Ohio). With a two-thirds vote required to send the resolution on to the House, the proposal carrying Senator Bricker's support at that stage, appeared dead. Several days later, however, Senator Lennon (D., N.C.), who was not present for final voting, but who was reported in favor of an amendment, filed a motion to reconsider the February 26 action. His motion can be brought up at any time during the remainder of this session by a simple majority and should it pass, then full debate would be resumed on the George amendment and an opportunity afforded Senators to change their vote.

The George amendment provides for enabling legislation by the Congress when any international agreement affects internal affairs; such legistion would require a majority vote. No enabling legislation would be necessary for treaties, although this was one of the key points in the Bricker proposal. On the question of treaty ratification, the George resolution requires a rollcall vote.

For those who favor some check on international agreements, the five week Senate debate on the amendment offered much to encourage, even though the resolution failed. The well publicized debate certainly interested a wide section of the public in the issue. Nearly two thirds of the Senators are now on record as wanting to curb executive agreements; one less opposition vote and the resolution would have carried by the required two thirds. Too, the sponsors of the resolution now know, as a result of the several separate votes, just which Senators oppose any sort of check, and which favor a restraint of some kind. Florida's Senators voted for the George amendment.

This legislation is very much the business of the medical profession. Did you, Doctor, express your appreciation to your Senator for the stand he took? Or your displeasure at the way he voted? Did you apprise him of your views during the five week period of debate? The American Medical Association supports a constitutional amendment along the lines proposed by Senators Bricker and George. It points out that without a change in the Constitution the social structure of the country, including the practice of medicine, can be altered by international agreements which can become domestic law even without enactment of Congressional legislation. Every practitioner of medicine would do well to keep informed on this matter for unless a safeguard is written into the Constitution, it is altogether possible that future international agreements will impose upon the profession and the nation social and medical care programs that the Congress itself would never enact. The Journal repeatedly has warned editorially of this insidious approach to socialized medicine.

Lay Medical Journalism Upbeat and Downbeat

The false hopes inspired by medical articles in lay magazines have become more and more of a problem for the physician. Magazines continue to deluge an avid public with a little learning that has become a dangerous thing, disrupting peace of mind and body far more than honest acceptance of the facts. What physician has not had patients, or their relatives, brandish some magazine article and demand to know why the particular treatment described has not been tried?

Popularization in this respect has gone too far in the opinion of a respected veteran writer of medical and psychologic articles for mass circulation magazines. In "Medical Journalism — With and Without Upbeat" Edith M. Stern recently discussed the pros and cons of this type of journalism.[1] The changing trend, as she depicts it, should offer some measure of welcome relief to the medical profession.

Since expert checking before publication is usually sought by reputable writers and editors, "factual inaccuracy as a rule is least among the factors which transmute what should be merely a report on a hopeful experiment into joyous hailing of a sure cure." One major factor is readers' wishful thinking. Another is the need of the highly competitive magazines for scoops, which leads to playing up new medical discoveries before time and further research play them down.

What physician will question the conclusion that medical articles cannot be properly appraised under the driers in beauty parlors or in train and plane seats? Rather, the author observes, they can be properly evaluated only in the perspective of medical libraries where, a wise old physician once told her, "You can find anything on either side of everything."

It seems it is the "upbeat," intrinsic in the formula for such articles, that is the chief cause of mass euphoria. The upbeat, to use the trade term, must be optimistic, encouraging, constructive, to keep the readers receptive to the upbeats in the advertising pages. True enough, the downbeats are there — shock treatment benefits are not always permanent, chest x-rays do not certainly detect lung cancer — but they are faint, and the tangential qualifying paragraph is apt to be lost in the plethora of words "angled" positively.

This torrent of popularization, as the doctor well knows, promotes undue fears as well as hopes. "Infantile paralysis, that hardy summer perennial on magazine covers, has been dramatized out of all proportion to its incidence," the author concedes. "Cancer, admittedly softpedaled for too long, has become terrifyingly fortissimo." Articles about dread diseases accord lip service to expert consultation — "see your doctor" becomes a familiar slogan — but here, too, the formula calls for throwing an idea out of focus. Self help is the upbeat, especially for women readers; the emphasis is on their doing something themselves about something.

This experienced author sees a tendency to correct some of the impressions made. "Caution" rather than "Eureka" is now the keynote in articles about antibiotics. Recently there has been mention of "disproportionate dread" of polio and even the suggestion that there are times to say "don't" to a child. These are signs that a saner approach may be in the offing.

The remedy suggested is not a moratorium on lay health articles, nor even the equivalent of "passing a law" to restrict medical information to polysyllabic journals. The simple prescription for ending the wrong kind of popularization is: "Publishers and publishers, editors and editors, writers and writers must make gentlemen's agreements among themselves never again to distort 'This is so' into 'This is it!' or to fan cool facts into hot news. All of us, no worse off competitively than we are now, ought to eat as well — and we would sleep better!" Most any physician would be happy to subscribe to that prescription and wish the writers sweet dreams.

1. Stern, Edith M.: Medical Journalism — With and Without Upbeat, The Saturday Review, Jan. 9, 1954, p. 9.

Hyacinths for the Soul

Throughout the 1953-1954 year concluded only a few days ago, the pithy remarks, sage observations and wise counsel appearing on the President's Page in The Journal gave pleasure and benefit to the members of the Association and brought them closer to their leader in understanding, objectives and outlook. Each monthly message was timely and to the point.

The March message from Dr. Herpel's pen was peculiarly suited to linger in the memory — indeed to serve as a welcome prod from time to time. "Broaden your horizon and widen your

margins" was the plea. The busy physician, engrossed in a modern medical or surgical practice is ready prey to the heavy professional demands day in and day out. It is easier to narrow than to broaden the horizon, harder to resist sinking into the groove of professional drive for success to the exclusion of other interests which likewise have valid claim. "Like a book whose contents fill all pages, leaving no room at the margins for casual notes during the reading thereof, so the life with a limited horizon fails to reach its fulfilment, and cannot attain the peak of service to which it should aspire."

In the quest for broader horizons and wider margins, the lift of the spirit will indeed more than compensate for the extra effort as well as for any material loss incurred. Dr. Herpel's prescription is good medicine:

"Do not be cramped in your outlook; laugh and be merry on occasion; be interested in those about you, and in what they are thinking and doing; have a care, unselfishly, for the ultimate good of all men, without regard for personal gain or glory; take an active part in community activities side by side with men of other professions and businesses; rub shoulders with the man in the street and get in touch with those about you."

It was an ancient Persian poet who said: "If thou hast two pennies, spend one for bread. With the other buy hyacinths for thy soul." A poetic turn of phrase, of course. But hard sense as well and in keeping with Dr. Herpel's philosophy. Buy hyacinths for your soul, and their fragrance will pervade and enrich your professional life.

Physicians' Military Service Outlook

During the next fiscal year, which begins on July 1, the Department of Defense will need about 4,500 physicians and expects that all hospital interns and residents obligated for military service will have to be called to active duty. Assistant Secretary Berry, in charge of medical and health matters for the Department, stated recently, however, that the demand may not be as heavy during the first half of the period because of a backlog of 1953 medical school graduates and a small number left over from Priority I. He urged hospitals to make short term arrangements for those facing almost inevitable call so that they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while they await orders the last six months of this year and the first six months of next year.

The National Advisory Committee to Selective Service advises that after July 1, 1955, all physicians with military obligations should obtain commissions during their internships. Doing so will remove them from the jurisdiction of their draft boards, and allow the Department of Defense to request delay in call for men the Department recommends for additional training. This information was also contained in a statement from Dr. Berry.

In addition, the result of a poll of medical school deans was presented by Dr. Berry. The deans were requested to ask fourth year students four questions: 1. If given free choice, which service would you prefer? 2. Do you prefer to serve your time immediately following internship? 3. Or following internship and one year of hospital training? 4. Or following full residency training? The Army was the choice of 27 per cent of the students, while 37 per cent preferred the Navy and 36 per cent the Air Force. Military duty immediately following internship was preferred by 39 per cent, after two years of hospital training by 15 per cent, and after full residency training by 46 per cent.

A. M. A. Clinical Session in Miami Meets One Day Earlier

The Clinical Session of the American Medical Association, which this year is scheduled to be held in Miami, will begin on Monday, November 29, and end on Thursday, December 2. Usually, the Clinical Sessions begin on Tuesday. The change was made recently by the A. M. A. Board of Trustees in order to give those attending the Miami session a longer weekend, either following or preceding the meeting. The Thursday before the session opens is Thanksgiving Day.

Seattle was chosen by the Board as the host city for the 1956 Clinical Session. The Clinical Sessions have been held in various sections of the country, coming this year for the first time to the far Southeastern section. The Seattle meeting will be the first to be held in the far Northwest.

Gamma Globulin Status

Spokesmen for the Health Resources Advisory Committee of Office of Defense Mobilization have announced that "ODM is prepared to continue administering the distribution of gamma globulin for polio next summer, provided a satisfactory plan is agreed upon. . . But (regardless) there would seem to be no reason . . . why it could not be distributed . . . and used by doctors as they see fit."

Earlier, a committee of experts sponsored by the United States Public Health Service announced after evaluating nationwide data on last summer's inoculations that gamma globulin inoculations have demonstrated no beneficial effects. This group, composed primarily of physicians, made its findings public after a three day session at the PHS Communicable Disease Center in Atlanta, Ga. The report stated: (1) Observation of communities where mass child inoculation was carried out does not provide sufficient evidence to determine the efficacy of the serum in preventing the disease or alleviating its effects. (2) Mass inoculations usually occurred after the epidemic peak, thus reducing evidence of its effect on the epidemic. (3) Family-contact administration of the serum (where all household members were inoculated immediately upon recognition of a polio case) did not appreciably lessen subsequent family incidence of paralytic polio. (4) Inoculation of exposed persons caused no measurable difference in the severity of ensuing paralysis. (5) More experience and greater opportunity for scientific investigation are necessary for proper evaluation of gamma globulin in mass inoculations.

Study Pesticide Poisoning Problem

Both physicians and the public are to be kept informed on the uses and dangers of various drugs, chemical products and pesticides used in and around the home. The Committee on Pesticides of the American Medical Association is undertaking a program for this purpose, and a companion group has been organized under the Council on Pharmacy and Chemistry. Their efforts will be integrated with those of other medical agencies conducting studies on health problems of household chemicals.

So far, the committee has compiled lists of trade names and case histories of poisonings from household chemicals. In addition, it has developed criteria for evaluating the safety of toxic materials and has prepared an exhibit, a radio transcription series, and a pamphlet urging the public to guard against poisonings resulting from household chemicals.

A physician member of the Congress, Rep. A. W. Miller (D., Neb.), has been warmly commended by the House Interstate and Foreign Commerce Committee for his work in bringing the many divergent interests together on a bill for more careful control of pesticide chemicals used in agricultural products. The bill results from a long series of hearings, starting three years ago. The main provision of the bill, Dr. Miller explained, requires that a tolerance be established before any pesticide can be put on the market. It also provides temporary tolerance for experimental purposes.

Graduate Medical Education Short Course July 12-16

The dates for the Twenty-Second Annual Graduate Short Course are later than has been customary in the past. The lectures will be presented the week of July 12-16 instead of late in June as heretofore because of the annual meeting of the American Medical Association at that time. The meeting place is as usual the George Washington Hotel in Jacksonville. The course will be concluded on Friday instead of Saturday noon as formerly. The Committee on Medical Postgraduate Course will be pleased to have the reaction of the members of the Association both to the change in dates and to the shortening of the course to five days.

Dr. Robert E. Cooke of Yale University will present the lectures on Pediatrics, Dr. Conrad G. Collins of Tulane University those on Gynecology, and Dr. Hans Lowenbach of Duke University those on psychiatry. As previously announced, Dean George T. Harrell of the University of Florida will lecture on Medicine, and Dr. H. Barton McSwain of Vanderbilt University will give the lectures on Surgery. The detailed program will be announced in the June issue of The Journal.

Rearrangement of the schedule incident to conflicting dates has necessitated postponement of the Seminar on Hematology planned for July 8-10, immediately preceding the Short Course.

This course is now being scheduled for November, and a nationally outstanding lecturer tentatively has been secured. It is expected that definite announcement regarding this Seminar will be made in the June Journal.

The Florida Clinical Diabetes Association will hold its second annual meeting at the San Juan Hotel in Orlando on October 21-22. In conjunction with this meeting there will be a two day Seminar on Diseases of Metabolism with particular reference to diabetes mellitus. The association and the Department of Medicine of the Graduate School of the University of Florida have secured two distinguished lecturers, Dr. H. B. Mulholland of the University of Virginia, who was well received when he appeared on the program in Lakeland in 1951, and Dr. Joseph T. Beardwood Jr., a distinguished internist of Philadelphia, who is well known for his studies in diabetes mellitus.

OTHERS ARE SAYING

Medical Outlay Rises

Spending for health soared last year to an all-time high as the U.S. public paid out $2.7 billion to physicians alone (the 1951 figure: $2.5 billion).

Nor were M.D.s the only practitioners who received substantial sums. According to a Department of Commerce "Survey of Current Business," dentists had their first billion-dollar year; osteopaths earned $128 million; and chiropractors took the public to the tune of $98 million.

How do such figures compare with other "personal consumption expenditures" (to borrow a term from the survey)? Answer: Health spending in 1952 was still just a drop in the bucket.

To pay for beauty care and aids, the nation laid $2.5 billion on the line. And for tobacco, pipes, and the like, $5 billion went up in smoke.

—Panorama, Medical Economics, October 1953

Frozen orange juice remains the fastest moving item on the grocer's shelf. Recently an Agriculture Department spokesman said that Americans are drinking it faster than it can be processed. This year 55,000,000 gallons will be consumed. Thirty per cent of the nation's families now use it. The demand for frozen orange juice is running 24 per cent ahead of the supply.

—The Pennsylvania Medical Journal, December 1953

Statistics show that only 5 per cent of the doctors in this country are women, as compared with 17 per cent in England and more than 50 per cent in the Soviet Union.

—Current Medical Digest, July 1953

Idealism in Medicine

Years ago a young man of our acquaintance, who was an honor student at college, was accepted by a Boston medical school. He did such good work that he ended the first semester with a score of seven A's in seven subjects. But he was asked to leave. The reason given was that the student's interest in medicine was mercenary. For that reason he would not be a credit to the medical school after graduation.

This courageous stand may have had a chastising effect on the young man. It certainly had a salutary effect on the minds of others in the class. The purpose of medical training was made very clear. In case we have forgotten, it is to use our talents and training to alleviate human suffering and to promote human health. Secondarily, we try to make a decent living.

The display of great wealth, where it is in obvious contrast to the illnesses of people with limited means, is in poor taste. It is not surprising if such display generates resentment. The medical school in question is to be complimented on its insistence on high ideals as well as high standards of scholarship. It would have been even better to be able to cull the mercenary type before admission. Much effort is spent in trying to do this, and this effort should be sustained and increased. The future of Medicine is no brighter than the ideals of its members, and the foundations for high professional standards are laid long before admission to medical school.

—Norfolk Medical News (Massachusetts) December 1953

Better County Society Programs

Progress in the medical profession has not been limited to advances in medical therapeutics and new surgical techniques. Medical progress also implies improved standards of medical ethics along with better understanding among physicians. Advances in this area can be facilitated in the future through better organized and more frequent meetings on the county society level.

Formerly, around the turn of the century, there was prevalent a "root-hog-or-die-poor" type of ethics, and postgraduate training was limited to the fortunate few. But now, in this age of rapid advances in medical knowledge, the physician can no longer complete his medical training, hang out his shingle, ignore his fellow physicians and practice medicine the remainder of his life without further training. Few, if any, physicians in present day practice would consider such a plan.

Today, the activities of the county society are considered an important part of the "postgraduate" training of the practicing physician. But, unfortunately, many small societies have been handicapped by their small membership. Scientific programs are held rarely or not at all. The members have been unable to attract well-trained speakers. To combat these disadvantages in size, several small county societies have joined together to form larger and better organized groups. Examples include the Randolph-Terrell, and Cherokee-Pickens Societies.

An objection to this scheme has been raised. It is maintained that the small county loses its identity and representation at the state convention when it merges with another society. For this reason several county societies are holding joint scientific meetings and retaining the integrity of their individual societies through separate business meetings.

Stephens and Habersham County Medical Societies are following this plan. Joint scientific meetings, alternating between Toccoa and Cornelia, are held by the two societies. Separate business meetings are held.

The hope of the medical profession today lies in the maintenance of a solid front against government administered medicine. This can only be assured by a unity of purpose among its individual members. It is felt that joint scientific meetings between small societies will promote better understanding between small, widely scattered groups and can make available to these groups more qualified speakers. The plan is recommended to other small county societies in Georgia.

George T. Nicholson, M.D.

—Journal of The Medical Association of Georgia, December 1953

"Patients Are People"

Perhaps the most frequently heard criticism of physicians is that they have become impersonal in their relations with patients. Medical leaders and others in the medical profession who have spoken on this subject have not hesitated to admit that to a considerable extent this is true. Among the major reasons given are overemphasis on science to the exclusion of the art of medicine, and specialization.

Dr. Josephine E. Renshaw, whose topic was "Patients Are People," is one of those who is inclined to go along with this view. People, she said, are asking, "Where is the old family doctor?" Dr. Renshaw contends that it is not the old family doctor people want but his sympathy and understanding.

She urged that whenever the opportunity offers, even when the patient comes in for routine examination, doctors not overlook the importance of the human touch. There are procedures in such examinations which, she said, "shock the patient's dignity. The experience is frightening to him." This could be minimized by doctors if they would take the time to explain the reasons for the procedure and what the trouble is. If this were done, she said, "patients won't be running off to look up their troubles and cures in magazines."

—Medical Annals of the District of Columbia, January 1954

Why Doctors Don't Read Their Mail

Doctor George F. Lull, Secretary, A.M.A., said: "Now I know why many doctors don't read all of their mail. The New England Medical Journal recently reported one doctor who received, from May 1, 1952 to April 30, 1953, a total of 3,305 pieces of direct mail advertising, with 2,883 pieces coming from pharmaceutical manufacturers. Products used in the treatment of cardiovascular disease headed the list. Antibiotics and sulfonamides came next."

—Nassau Medical News (New York), December 1953

BIRTHS AND DEATHS

Births

Dr. and Mrs. Edward G. Jeruss of Miami announce the birth of a son, Jeffrey Glenn, on March 4, 1954.

Dr. and Mrs. Louis A. Wilensky of Jacksonville announce the birth of a son, Robert Bruce, on March 11, 1954.

Dr. and Mrs. Thomas Armour Jr. of Coral Gables announce the birth of a son, James Calhoun, on March 13, 1954.

Deaths — Members

Kennedy, David R., Paducah, Ky. ..... March 24, 1954
Boling, John R., Tampa ..... April 12, 1954

Deaths — Other Doctors

Foy, Eugene T., Pensacola ..... Feb. 26, 1954

Medical Officers Returned

Dr. Edward F. Meares, who entered military service on Jan. 31, 1951, was released from active duty on Jan. 31, 1953 with the rank of lieutenant, jg (MC), U. S. Naval Reserve. His address is Fairfield State Hospital, Newtown, Conn.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Alterman, Seymour L., Miami Beach
Anderson, Russell L. (Col.), Tallahassee
Andrews, Robert J., Miami
Berezney, Paul L., St. Petersburg
Berry, Carl Z., St. Petersburg
Bixler, Thomas J., Tallahassee
Caldwell, Frederic E., Mary Esther
Capi, Andre S., Hollywood
Carlisle, James M., Pensacola
Coggan, George M., Sarasota
Coggins, Deborah R., Boca Grande
Cohen, Maurice, Crestview
Conrad, Elmer R., Fort Lauderdale
Cornille, Alfred J., Fort Pierce
Cullen, Marvin L., Tampa
Denham, Sam W., Jacksonville
Frell, Joseph C., Miami Springs
Giffin, Allyn B., St. Petersburg
Glennan, Thomas L., Green Cove Springs
Golinvaux, C. J., Surfside
Guest, Maurice C., Orlando
Haston, Hugh B. Jr., Jacksonville
Hilbert, Gerard H., Pensacola
Hobach, George B., St. Petersburg
Hutchins, Paul F., Jacksonville
Jeruss, Edward G., Miami
Kafka, Richard M., Tampa
Kobak, Mathew W., Miami Beach
Langston, Richard J., St. Augustine
Lev, Maurice, Miami Beach
McIntyre, Clifford E. L., Fort Lauderdale
McKeever, Robert J., St. Petersburg
Meitus, Marvin L., Miami Beach
Mickley, John H., Hollywood
Miller, Allen L. Jr., Pensacola
Morse, Alexander E. Jr., Mount Dora
Neil, Robert L., Clearwater
Osterman, Floyd A., Fort Lauderdale
Parker, Howard A., Valparaiso
Peretti, Alfred P., Palatka
Register, Samuel T., Clearwater
Rozier, Jacob R., Winter Park
Scandiffio, Mario V., North Miami
Schlapik, Daniel D., Miami
Shulack, Norman R., Miami
Silverstone, Eugene H., Coral Gables
Simpson, James W., Orlando
Smith, Sidney, Bradenton
Tainter, Rolfe, Winter Park
Wellborn, Walter H., Tampa
Zavertnik, Joseph J., Miami

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P.O. Box 1018, Jacksonville, Fla.

Name _____
(Please print)

Old Address:

Street _____

City & Zone _____

State _____

New Address:

Street _____

City & Zone _____

State _____

STATE NEWS ITEMS

Dr. Donald H. Gahagen of Fort Lauderdale was a guest speaker at a meeting of the Rotary Ann Club of Hollywood in March.

Dr. J. M. Ingram Jr. of Tampa spoke on the medical aspects of cancer at the Regional Cancer Crusade Meeting of the Florida division in Tampa in February. Dr. Marshall E. Smith of Tampa talked on the tumor clinic, and Dr. Thomasson P. Dann of St. Petersburg explained the importance of public education.

Dr. Raymond R. Sessions of Kissimmee has returned to his practice following a seven weeks postgraduate course at Cook County Postgraduate School of Medicine in Chicago.

Drs. Hiram B. Curry of Jasper, William P. Blackmon of Mayo. Edward G. Haskell Jr. of Branford. and Irby H. Black. John N. Sims Sr., J. Dillard Workman and Joshua M. Price of Live Oak took part in a forum on the heart at a meeting of the Woman's Club of Live Oak on March 5.

Dr. Philipp R. Rezek of Miami spoke on "Suicide and Insanity" at the sixth annual meeting of the American Academy of Forensic Sciences held in Chicago in February.

Dr. Jere W. Annis of Lakeland spoke at the annual Award Meeting of the Palm Beach County Heart Association on February 25.

Dr. Edward W. Cullipher of Miami delivered the graduation address at the third annual graduation exercises of the Practical Nurse Training Program, Lindsey Hopkins Vocational School.

Dr. Thad Moseley of Jacksonville presented a paper on "The Surgical Treatment of Gastrojejunocolic Fistula." at the Twenty-Second Annual Assembly of the Southeastern Surgical Congress in Birmingham, Ala., in March.

Dr. William C. Blake of Tampa was speaker at an open forum on heart diseases held at the auditorium of Pasco High School in Lakeland in February.

Dr. Addison L. Messer of St. Petersburg spoke on "The Newer Drugs in Cardiology" before the Private Duty Section of the Pinellas County Nurses, District 13, on February 24.

Dr. Wade C. Myers Jr. of Tampa spoke on "A Review of Presacral Tumors and a Report of a Case of Presacral Dermoid" at the March meeting of the Southeastern Surgical Congress in Birmingham, Ala.

Dr. James A. Poyner of Panama City entered military service with the U. S. Air Force on April 19, 1953. He holds the rank of captain.

Dr. F. Gordon King of Jacksonville was guest speaker at the regular monthly meeting of the Junior Woman's Club of Jacksonville in March. His subject was "Socialized Medicine."

Dr. Edward R. Annis of Miami was chairman of the steering committee to plan the Archbishop's Annual Charity Dinner for Mercy Hospital on April 19.

Dr. Lucien Y. Dyrenforth of Jacksonville spoke on "Cancer and Allied Diseases" at the March meeting of the Medical Assistants Association of Jacksonville.

Dr. Louis M. Orr of Orlando spoke on "Radio Active Isotopes in the Treatment of Cancer of the Prostate" at the Twenty-Second Annual Assembly of the Southeastern Surgical Congress in Birmingham, March 8-11.

Dr. Carl C. Mendoza of Jacksonville gave a report on progress in cancer detection and cure at a Zonta Club meeting in February.

Dr. Walter R. Newbern of West Palm Beach was a guest speaker at the social meeting of Palm Beach Unit 12, American Legion Auxiliary, March 8, at the Legion Home. A film on "Self-Examination for Breast Cancer" was shown.

The following Jacksonville doctors gave talks on cancer during February and March: Dr. Frederick H. Bowen before the Murray Hill Baptist Woman's Missionary Society and the Woman's Auxiliary of the Church of the Good Shepherd; Dr. J. Brooks Brown before the Exchange Club monthly luncheon meeting; Dr. Edward Canipelli at the Norwood P.-T.A. meeting; Dr. John J. Fisher before a meeting of the Andrew Jackson High School Dads' Club; Dr. Matthew E. Morrow Jr. at a meeting of the St. John's D.A.R.; Dr. C. Burling Roesch before the West Riverside School Dads' Club; Dr. Sidney Stillman before the Lola M. Culver School Dads' Club; and Dr. Jonathan H. Wood at a meeting of the Kiwanis Club.

Dr. Samuel A. King of Avon Park has returned to his practice after attending a graduate study course on heart diseases at the Tulane University of Louisiana School of Medicine.

Dr. Edgar Watson of Lakeland spoke at a meeting of the Florida State Nurses' Association in March. His subject was the tumor clinic.

Dr. Wilbur C. Sumner of Jacksonville spoke on lung cancer at a meeting of the Jacksonville Junior Chamber of Commerce on March 2.

Dr. William D. Cawthon of DeFuniak Springs has been appointed a delegate to represent Florida at the national meetings of the American Heart Association.

Dr. Edward Jelks of Jacksonville spoke before a Jacksonville Junior College Assembly on March 24. His subject was "Choosing Medicine as a Career."

Dr. C. Ashley Bird of Jacksonville spoke at the regular monthly meeting of the St. Johns County Medical Society in March.

Dr. H. Phillip Hampton of Tampa was featured speaker on a program of weight control and nutrition presented on March 2 in the home demonstration auditorium of the County Court House in Tampa. Dr. Frank V. Chappell of Tampa made the introductory talk before Dr. Hampton spoke on "The Importance of Weight Control."

Dr. Thomas S. Field of Jacksonville was guest of honor at the Phi Delta Theta Founders' Day Dinner in Jacksonville in March.

At a meeting of the Jacksonville Dermatologists in February, Dr. J. R. Driver of Cleveland spoke on "Treatment of Cutaneous Malignancies." Drs. Jack H. Bowen, William C. Croom Jr., Joseph A. J. Farrington, Lauren M. Sompayrac and J. Frank Wilson, all of Jacksonville, attended.

The following doctors in the Miami area have recently spoken at various meetings: Dr. Raymond Breitbart of Miami Beach at the Civic League; Dr. John R. Ramey of Miami at the Miami Shores Optimist Club; Dr. James G. Robinson of Miami at the Hialeah Club for Self Improvement; Dr. Harold S. Kaufman of Miami Beach before the B'nai B'rith Youth Organization and the Housekeepers Club of Coconut Grove; Dr. Edward R. Annis of Miami before the South Miami Rotary Club and the Lions Club of Miami Springs; Dr. Walter W. Sackett Jr. of Miami at a meeting of the Italian American Woman's Club; Dr. R. Spencer Howell of Miami before the George A. Brendla Auxiliary; Dr. C. Howard McDevitt Jr. of Coral Gables before the Wac-Vets Post 98; Dr. Bruce M. Hogg of Miami before the Woman's Auxiliary, Miami Power Squadron, Florida Power and Light Company; Dr. Truxton L. Jackson of Miami before the Coral Gables Lions Club; Dr. Richard C. Clay before meetings of the Coconut Grove Exchange Club and the Miami Springs Woman's Club; Dr. George F. Schmitt Jr. of Miami at the U. S. Naval Hospital, Key West; Dr. Raymond L. Evans of Miami before the Coral Gables American Legion Auxiliary; Dr. Vincent P. Corso of Miami at the Benjamin Franklin Elementary School; Dr. Ralph W. Jack of Miami at the Cancer Institute at Miami; and Dr. Robert M. Lee of Miami at Miami Jackson High School.

Dr. James N. Patterson of Tampa is taking a six weeks course in hematology at the University of Pennsylvania Postgraduate School of Medicine in Philadelphia.

Dr. Ashbel C. Williams of Jacksonville attended a meeting of the Ewing Society in New York City in March.

Dr. Lawrence E. Geeslin of Jacksonville has been elected vice president of the Jacksonville Community Chest-United Fund for the coming year.

Dr. Clarence M. Sharp of Jacksonville spoke on "Tuberculosis Control" at the Florida Health Officers Conference held in Jacksonville in February.

Drs. Turner Z. Cason of Jacksonville and William C. Blake of Tampa attended the meeting of the American College of Physicians in Chicago in April. Dr. Blake is the governor for Florida.

Drs. Hugh E. Parsons, R. Renfro Duke and Sherman B. Forbes of Tampa, Dr. William Y. Sayad of West Palm Beach, Dr. W. Jerome Knauer Sr. of Jacksonville, Dr. Henry J. Wiser of Winter Park, and Dr. William J. Knauer Jr. of Washington, D. C., all attended the Thirteenth Clinical Meeting of the Wilmer Residents Association, The Wilmer Ophthalmological Institute, The Johns Hopkins Hospital and University, Baltimore, Md., April 1-3.

Dr. Nathaniel M. Levin of Miami has returned to his practice after completing a course in advanced ear surgery in New York City.

Dr. Nelson Zivitz of Miami Beach, assisted by Drs. Harold Rand and James H. Putman of Miami, was chairman of the arrangements committee for the meeting of the American College of Allergists held at the Roney Plaza Hotel, Miami Beach, April 5-10.

Drs. George W. Morse and Egbert V. Anderson of Pensacola have returned to their practices after attending a special postgraduate course in pediatrics at the Tulane University School of Medicine in New Orleans.

Dr. Francis P. Cassidy of Pensacola attended a special postgraduate seminar on diseases of the chest at the Tulane University School of Medicine in New Orleans in February.

The Medical Library Association will hold its Fifty-Third Annual Meeting June 15-18, 1954, in Washington, D.C. The headquarters will be the Hotel Statler, and the official host the Armed Forces Medical Library.

The program will include a discussion on medical research by embassy attaches, tours of the National Institutes of Health, the National Naval Medical Center, and the Armed Forces Medical Library. Delegates to the meeting will hear addresses by Dr. Detlev Bronk, President of the Rockefeller Institute of Medical Research, Lt. Col. Frank B. Rogers, Director of the Armed Forces Medical Library, Mr. Verner Clapp, the Acting Librarian of Congress, and Dr. Raymond Zwemer, Chief of the Library of Congress' Science Division.

Dr. Paul W. Morgan of Winter Haven entered military service with the U. S. Naval Reserve on Nov. 10, 1953, with the rank of lieutenant.

Drs. Richard A. Worsham and Paul F. Hutchins of Jacksonville have returned to their practices after attending a postgraduate course in hand surgery at the Tulane University Graduate School in New Orleans in March.

Drs. William C. Croom Jr., John J. Fisher, A. Judson Graves, Samuel S. Lombardo, Nelson A. Murray and Lorenzo L. Parks of Jacksonville took part in a panel discussion on cancer before a Cancer Nursing Institute held in Jacksonville in February.

Dr. Thomas M. Irwin of Jacksonville attended a meeting of the Georgia Eye, Ear, Nose and Throat Society in Savannah in March.

The Thirty-Second Annual Scientific and Clinical Session of the American Congress of Physical Medicine and Rehabilitation will be held Sept. 6-11, 1954, at the Hotel Statler, Washington, D. C.

Proceedings of Eightieth Annual Meeting Scheduled for Publication in the June Issue

WANTED — FOR SALE

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

SURGEON: Age 39, F.A.C.S. and Board Eligible, seeking association with older surgeon, or community in need of a well trained general surgeon. Has Florida license. Write 69-106, P. O. Box 1018, Jacksonville, Fla.

GENERAL SURGEON: 38; Board certified; training just completed; category IV; family; Florida license; University training; desires association or partnership leading to a permanent position. Write 69-112, P.O. Box 1018, Jacksonville, Fla.

SITUATION WANTED: Young, married, veteran, graduate Medical College of Georgia. Florida license. Internship Ohio State University Hospital. Desires association with group or individual, general practice, Florida. Write 69-117, P. O. Box 1018, Jacksonville, Fla.

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GENERAL PRACTICE: Clinic in southeast Florida losing one physician — needs replacement. Either salaried, commissioned or private rental basis. Excellent opportunities, good hospital facilities. Write 69-122, P. O. Box 1018, Jacksonville, Fla.

SITUATION WANTED: Desire General Practice position or association, preferably Central Florida; 28 years old, married, Tulane graduate, rotating internship plus time in Army, Florida license, available June. Write 69-123, P.O. Box 1018, Jacksonville, Fla.

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COMPONENT SOCIETY NOTES

Brevard

The Brevard County Medical Society in conjunction with the American Cancer Society urged every woman in the area to attend the film, "Self Examination of the Breast," which was shown there in April.

Dade

"Blood Coagulation Factors in Hemorrhagic Disease" was the title of the scientific paper presented by Dr. John Miale at the April meeting of the Dade County Medical Association.

Duval

At the regular monthly meeting of the Duval County Medical Society on April 6, Dr. Bernard J. McCloskey of Jacksonville spoke on "Etiology, Diagnosis and Treatment of Common Allergic Disorders."

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on April 5, Dr. E. L. Carter was guest speaker. His subject was "Treatment with Ultra Sound Waves."

Indian River

Dr. Stan Meurling, prominent Swedish surgeon, was guest speaker at the regular monthly meeting of the Indian River County Medical Society in March. Dr. Meurling, who is associate professor of surgery at the University of Upsale in Sweden and chief of surgery at the university hospital, spoke on "The Practice of Medicine in Sweden."

Jackson-Calhoun

A film on Amebiasis was shown at the March meeting of the Jackson-Calhoun County Medical Society in Marianna.

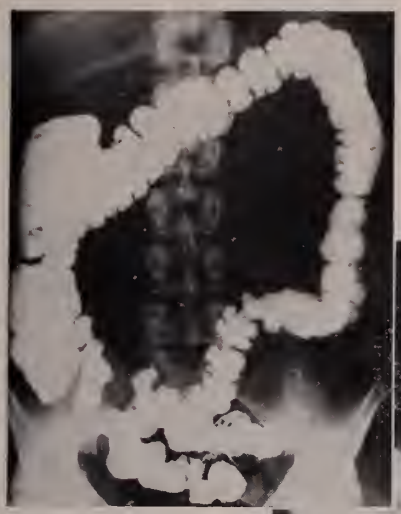
Manatee

Dr. Roscoe Roy Spencer, retired Medical Director of National Cancer Institute, U. S. Public Health Service, was the speaker at a joint dinner meeting of the Manatee and Sarasota County Medical Societies in March. He spoke on "The Meaning of New Growth as Related to Cancer."

Marion

At the regular March meeting of the Marion County Medical Society, it was voted to endow a room in the new addition of the Munroe Memorial Hospital in Ocala.

(Continued on page 840)



Normal Colon



Ulcerative Colitis



Atonic Colon

Smoothage and Bulk in Correcting Constipation

To initiate the normal defecation reflex, the "smoothage" and bulk of Metamucil® provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the "irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

(Continued from page 838)

Palm Beach

Members of the Palm Beach County Medical Society have passed a resolution requesting city managers of Palm Beach, West Palm Beach and Lake Worth to have notices placed along the lake shores advising of the lake's heavy pollution as a protection for those who, unknowingly, might swim or wade in its waters.



Pinellas

At the regular April meeting of the Pinellas County Medical Society, Attorney Morris White of Tampa spoke on "Medical Jurisprudence."

St. Johns

At the regular monthly meeting of the St. Johns County Medical Society on March 16, Dr. C. Ashley Bird of Jacksonville spoke on "Diagnosis and Treatment of Head Injuries."

Sarasota

At a joint meeting of the Sarasota and Manatee County Medical Societies on March 9, Dr. Roscoe Roy Spencer, retired Medical Director of National Cancer Institute, U. S. Public Health Service, was the speaker. His subject was "The Meaning of New Growth as Related to Cancer." The meeting was held at the Sarasota Bay Country Club.

BRAWNER'S SANITARIUM

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Assistant Director and Superintendent

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P. O. Box 218

Phone 5-4486

OBITUARIES

Gerald Joseph Walsh

Dr. Gerald Joseph Walsh of Miami died on Feb. 7, 1954 at his home in Miami Shores. He was 47 years of age.

A native of Montreal, Canada, where he was born in 1906, Dr. Walsh attended Loyola University in that city. Later he received a degree in chemical engineering from Georgia Institute of Technology. In 1937 he was awarded the degree of Doctor of Medicine by McGill University Faculty of Medicine in Montreal.

In 1939, Dr. Walsh engaged in the practice of medicine in Miami, where he was a founder of the Walsh, Fischer and Ryon Medical Center. During World War II he served in the Medical Corps of the Army with the rank of captain. He was a member of the American Legion and the Nu Sigma Nu medical fraternity.

Dr. Walsh was a member of the Dade County Medical Association. He became a member of the Florida Medical Association in 1938 and for the last five years had held honorary status. He also held membership in the American Medical Association and the Canadian Medical Association.

Surviving are the widow, Mrs. Marjorie Walsh, and one daughter, Anne, both of Miami; his father, Justice Joseph Walsh of the Court of Appeals for the Quebec Province, Montreal; and a sister, Mrs. Armoury Boisard, also of Montreal.



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Thomas Clair Maguire

Dr. Thomas Clair Maguire of Plant City died in his sleep at his home on Jan. 29, 1954. He was 72 years of age.

Born in Walnut Grove, Ga., on May 13, 1881, Dr. Maguire came with his parents to Florida in 1885. In 1890, the Maguire family moved from their home in Winter Garden to Ocoee, where Dr. Maguire attended public schools. He entered Florida Agricultural College at Lake City in 1900 and became the first president of the Kappa Alpha fraternity chapter. He was valedictorian of the class of 1905, and immediately thereafter the Lake City college was moved to Gainesville to become the University of Florida. He then entered the University of Louisville School of Medicine, where he was awarded the degree of Doctor of Medicine in 1908.

Shortly after graduation Dr. Maguire located in Plant City and continued to engage in the general practice of medicine and surgery there for 46 years. In 1914 he gave Plant City its first hospital, a private institution which he operated until four years before his death when failing health compelled him to close it. For several years he had practiced only on a limited scale, spending a few hours each morning in his office. On May 13, 1953, his seventy-second birthday, Dr. Maguire was honored appropriately at a large public party at the newly reactivated Plant City Golf and Country Club. He was a charter member of the original Golf Club, and until the last few years was an enthusiastic golfer. Hundreds paid tribute to him on that occasion, and it was estimated at that time that he had delivered between 3,000 and 4,000 babies in East Hillsborough County. Locally, he was chairman of the board of directors of the recently completed South Florida Baptist Hospital, of which he had been an early supporter.

Dr. Maguire was a member and past president of the Hillsborough County Medical Association. Since 1914 he had been a member of the Florida Medical Association, becoming a life member six years ago. He also held membership in the American Medical Association.

Surviving are the widow, Mrs. Connie Zelle Maguire; a stepson, W. D. Elliott, of Astor Park; a brother, Raymer Maguire, of Orlando; a sister, Miss Lillian Maguire, of Ocoee; and a granddaughter, Mrs. Anne Elliott Horne, of Wyoming.

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John Flavel Wilson

Dr. John Flavel Wilson of Lakeland died on Jan. 31, 1954 at Morrell Memorial Hospital after a long illness. He was 75 years of age.

A native of Anderson, S. C., Dr. Wilson was born in 1878. He received the degree of Doctor of Medicine from the Medical College of the State of South Carolina in 1905. The following year he entered the practice of medicine in Lakeland and continued in practice there for 48 years. He was active in civic and fraternal affairs. At one time he was city health officer and also served on the city school board. He was a steward of the First Methodist Church. For 24 years he was the physician for Florida Southern College, and since locating in Lakeland in 1906 he had been the medical examiner and surgeon for the Atlantic Coast Line Railroad. For 52 years he had been a Mason and was a member of the Shrine Club, the Royal Arch Masons, the Knights of the Red Cross of Constantine, and the Sons of the American Revolution.

Dr. Wilson was a charter member of the Polk County Medical Association. He had for 42 years been a member of the Florida Medical Association, becoming a life member seven years ago, and also held membership in the American Medical Association and the Southern Medical Association.

His widow, Mrs. Martha Cason Wilson, of Lakeland, and one daughter, Mrs. James Montie Rea, of Pittsburgh, Pa., survive him. Other survivors include one sister, Miss C. Elizabeth Wilson, and one brother, Edwards A. Wilson, both of Darlington, S. C.; two aunts, Mrs. Robert Lide, of Florence, S. C., and Miss Sue Wilson, of Society Hill, S. C.: and three grandchildren, Marthann Rea, a student at Florida Southern College, and J. Montie Rea Jr., and Claribel Rea, both of Pittsburgh.

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Associate Medical Director

Roger Waldrick Gridley

Dr. Roger Waldrick Gridley of Orlando died in a private plane accident near Wewahotee on Jan. 31, 1954. He was 40 years of age.

Born in Springfield, Ohio, on June 30, 1913, Dr. Gridley received his medical training in his native state. He was graduated from the Ohio State University College of Medicine in Columbus in 1945. He then served a rotating internship at Orange Memorial Hospital in Orlando before being called to active duty in the Medical Corps of the Army of the United States with the rank of first lieutenant in July 1946. In September of that year he was ordered to the U. S. Veterans Hospital at McKinney, Texas, for a residency in anesthesiology. This residency, which included a seven months' course in general surgery at Southwestern Medical College in Dallas, was completed in June 1948. That same month he was discharged from the Army with the rank of captain. He then served a fellowship in anesthesiology with Doctors Kreisleman, Bruner and Stubbs in Washington, D. C. He received his license to practice medicine in Ohio in July 1945 and in Florida in August 1946.

Since January 1949 Dr. Gridley had engaged in the private practice of anesthesiology in Orlando. Physicians, parents and children alike will remember that it was his special interest to eliminate the frightening aspects of anesthesia and surgical procedures for children, and to make the child's hospital experience a pleasant one. His interests outside of medicine were varied and included flying, fishing, music, painting and short story writing. Locally, he was a member of the Presbyterian Church and the Orlando Executive Club. His fraternity was Alpha Kappa Kappa.

Dr. Gridley was a member of the Orange County Medical Society and for five years had held membership in the Florida Medical Association. He was also a member of the American Medical Association and the American Association of Anesthesiologists.

On Sept. 19, 1943, Dr. Gridley was married to Virginia Beuttel, who survives him. Other survivors include two daughters, Carla Moss and Melissa Jane Gridley; one son, Roger Waldrick Gridley Jr., of South Fort Mitchell, Ky.; two brothers, Robert Q. Gridley, of Springfield, Ohio, and Chester G. Gridley, of Orlando; and four sisters, Mrs. Margaret Neer, of Urbana, Ohio, and Mrs. Martha Dailey, Mrs. Grace O'Connor and Mrs. Anna Fitzgiven, all of Springfield, Ohio.

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BOOKS RECEIVED

School Health Services. A Report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association with the cooperation of contributors and consultants. By Charles C. Wilson, M.D., Editor. Pp. 486. Price, $5.00. National Education Association and American Medical Association, 1953.

This modern comprehensive guide for health procedures in small or large school systems has been prepared with the expectation that its functional organization and its presentation of specific recommendations and practical illustrations will make it useful to all concerned with school health activities. The book is designed as a reference for teachers and school administrators, for health educators, physical educators, and teachers of the handicapped, for physicians, dentists, nurses and dental hygienists, for public health administrators, and for psychologists and social workers. It is an appropriate text for institutions preparing physicians, public health workers, or teachers. It serves as a companion volume to Health Education, a publication which is now used extensively throughout the schools and colleges of the country.

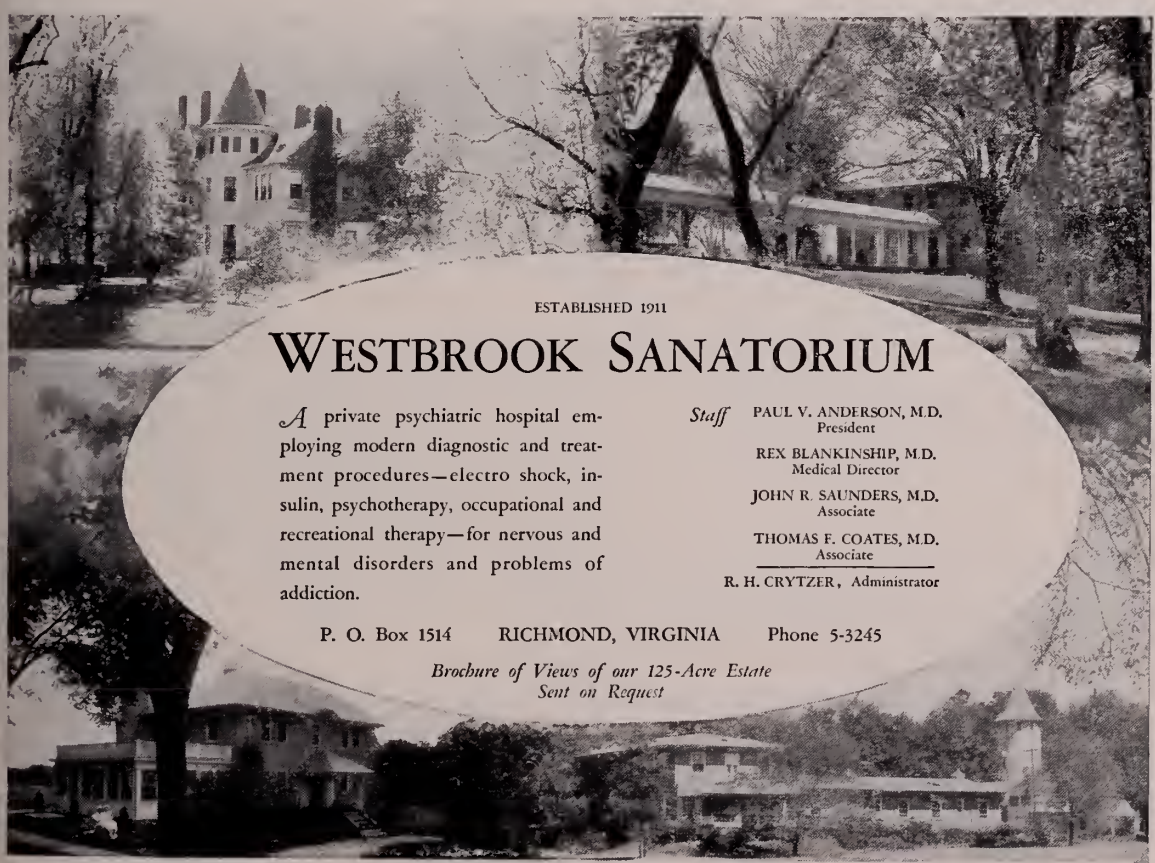
School Health Services describes the health responsibilities of schools and stresses the need for coordination of school efforts with those of parents, departments of health, private practitioners of medicine and dentistry, and community health agencies. Particular attention is given to the role of the teacher in school health services and to the desirability of utilizing service activities for health education purposes. The relationships between health services and health education are discussed in relation to numerous aspects of school health services.

The editor is Charles C. Wilson, M.D., Professor of Education and Public Health, Yale University. The book may be ordered from the American Medical Association, 535 North Dearborn Street, Chicago 10, or the National Education Association of the United States, 1201 Sixteenth Street, N.W., Washington 6, D. C.

You and Your Health. By Edwin P. Jordan, M.D. Pp. 296. Price, $3.95. New York, G. P. Putnam's Sons, 1954.

Since most people want to know more about their own and their families' ailments than their doctors have time to tell them, this book is designed to bridge this gap by giving as much information as possible about the nature of the various diseases so that the patient can carry out his doctor's orders more intelligently. It is based upon the axiom that the best patient is a well informed patient, a patient who realizes the nature of his illness, the probable course it will take, and how soon he should recover.

In informal, nontechnical style, the book discusses almost every medical problem from care of the skin to cancer. The reader finds in its pages just what his doctor wants him to know about the nature of the various diseases and ailments to which the human body is subject. Each chapter is followed by a series of questions and answers. The questions, carefully selected by Dr. Jordan, represent those he is most frequently asked by readers of his newspaper column. The book, however, is not a substitute for medical care. It is by no means a "self-treatment" book.



Children for the Childless. Edited by Morris Fishbein, M.D. Pp. 223. Price, $2.95. Garden City, N. Y., Doubleday & Company, Inc., 1954.

Released in March 1954, this book is a concise explanation of the medical, scientific, and legal facts of fertility, sterility, heredity, and adoption. Used in conjunction with visits to the family physician, it is a handbook for the single and the married and a source of hope for the childless.

Under the editorship of Dr. Morris Fishbein, experts have contributed the sum total of their precise knowledge to give a popular and graphic yet authoritative up-to-date manual for easy reading and reference. It answers such questions as: What effect do the physical, psychologic, social, and economic factors have on fertility and sterility? What are the methods and technics used to explore these matters? What is the chance for children for those couples who, desiring children, remain childless?

The eight chapters include: "On Being a Parent Today" by Sidonie Matsner Gruenberg; "Physical Aspects of Fertility and Sterility" by Morris Fishbein, M.D.; "Psychosomatic Aspects of Fertility and Sterility" by Edward Weiss, M.D.; "Human Sterility" by I. C. Rubin, M.D.; "Human Fertility" by Nicholson J. Eastman, M.D.; "Artificial Insemination" by J. P. Greenhil, M.D.; "Adoption" by Fred B. Kyger, M.D., and Richard L. Jenkins, M.D.; and "What Will Our Child Be Like?" by Benjamin C. Gruenberg, Ph.D.

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NOTICE

Old officers and committee chairmen appear in this May Journal since it went to press before the election of officers at the annual meeting, April 26. New officers and committee chairmen will appear in your June Journal.

Portrait of a Doctor's Wife

It is interesting in parallel to notice that the medical auxiliary is the sum total of all the qualities desirable in a doctor's wife — that the success of one is dependent upon the other in a reverse sort of way. The organization corresponds to human personality in such a way that unless the function assumed by each person is effectively performed, the organizational body falters and becomes inadequate in spirit.

Each person who assumes a chairmanship becomes a facet of organizational personality development. As the individual body requires efficient cooperation of its members to function, so an organizational body depends upon the will and creative impulse of its chairman and members to maintain its stability and ability to function.

In a medical auxiliary, for instance, the chairmanships could be incorporated into one's daily living like facets of a well integrated person:

Organization	Public Relations
Program	Bulletin, Medaux, Today's Health
Study Group	Mental Health
Legislation	Nurse Recruitment, Civil Defense
Hospitality, Finance, Parliamentarian	

The executive group is comparable to a person's thought direction, and when the topics of interest in a person's life embrace the above subjects you have a contributor to medical interests. For when a doctor's wife sets out to have ORGANIZATION in her personal life, she plans it, which is also a PROGRAM for living. An interest in STUDY GROUPS keeps her alert to LEGISLATION, TODAY'S HEALTH, the BULLETIN and MAGAZINE of her auxiliary affairs, which in turn makes it possible to practice good PUBLIC RELATIONS which usually embraces NURSE RECRUITMENT, CIVIL DEFENSE and other civic and philanthropic endeavors.

The MENTAL HEALTH of such a personality dedicated to service to others is sound and results in a spirit of HOSPITALITY which is FINANCED by a sense of proportion, and the order of her behavior rarely needs a PARLIAMENTARIAN.

By using the chairmanships one can see that we draw a portrait of a lady who is qualified to be a doctor's wife. An organization made up of such persons cannot help being a source of good.

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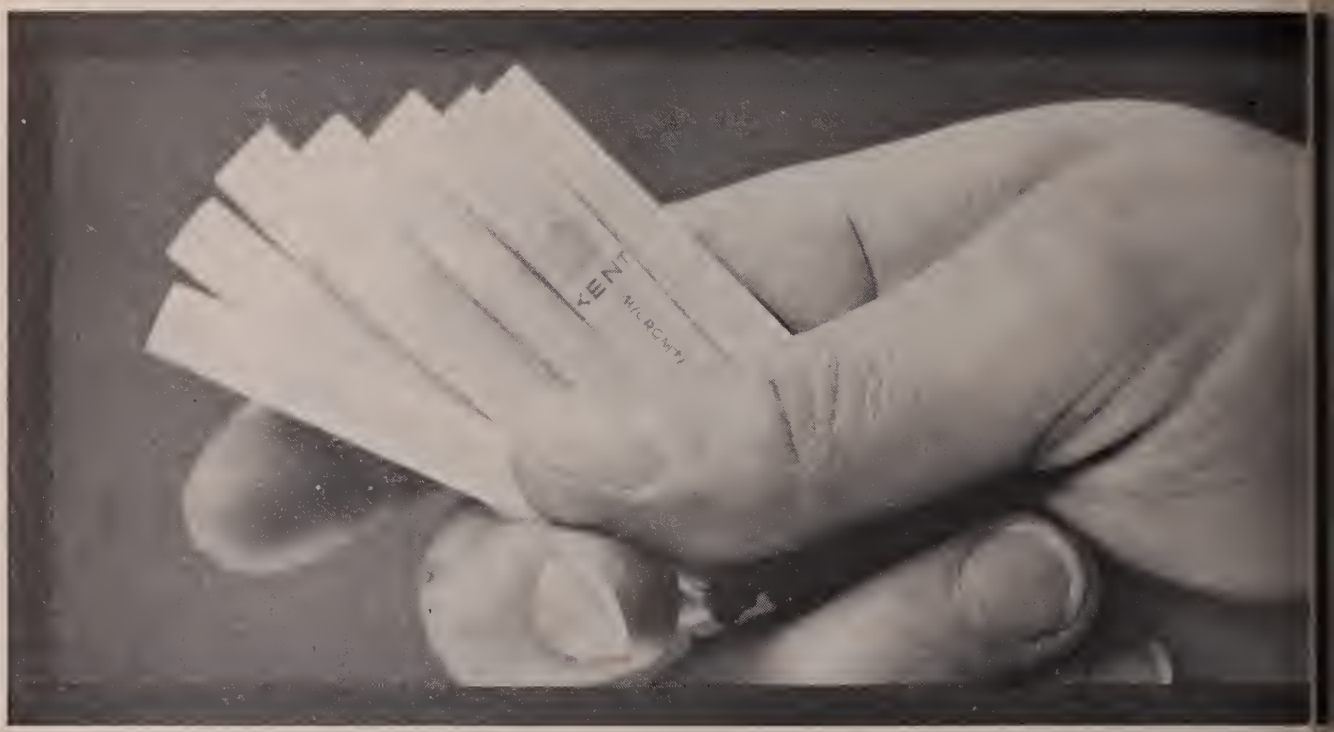
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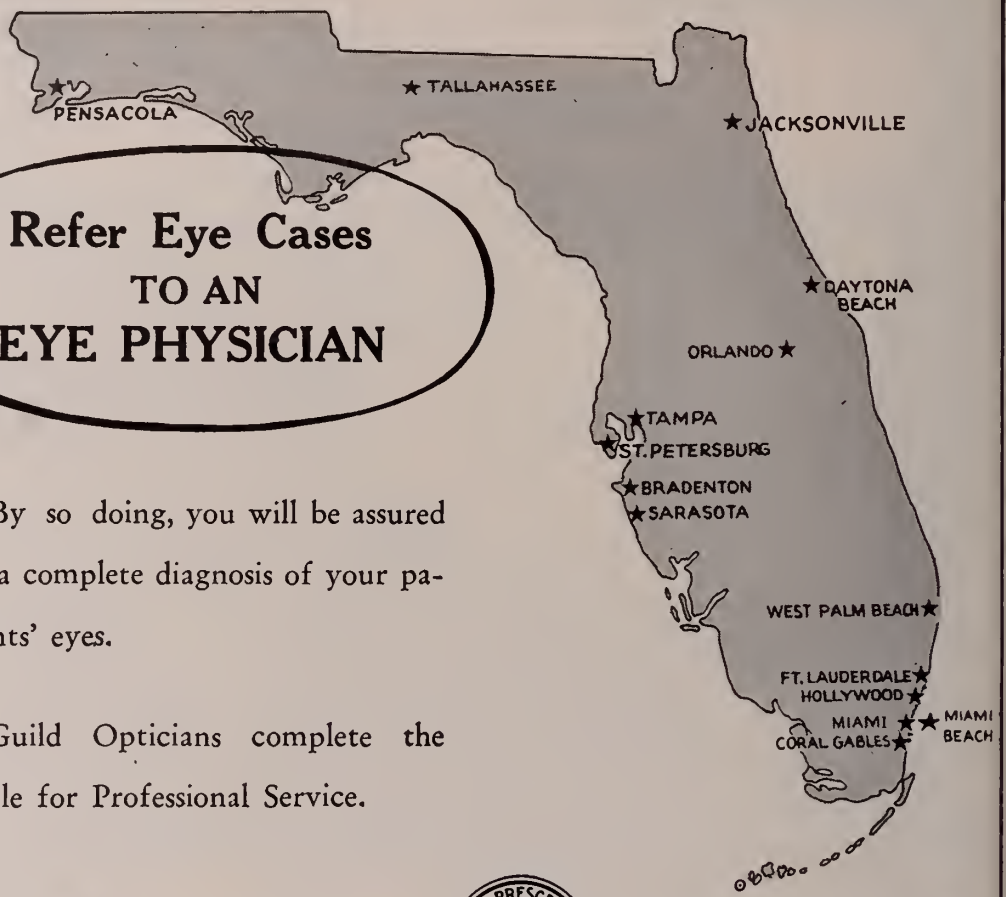
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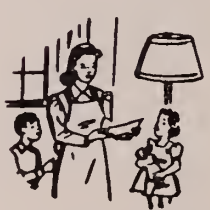
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St. Petersburg	509 White Building	Daytona Beach	116½ Orange Avenue
Lakeland	206 Marble Arcade	Pensacola	501 Theisen Building
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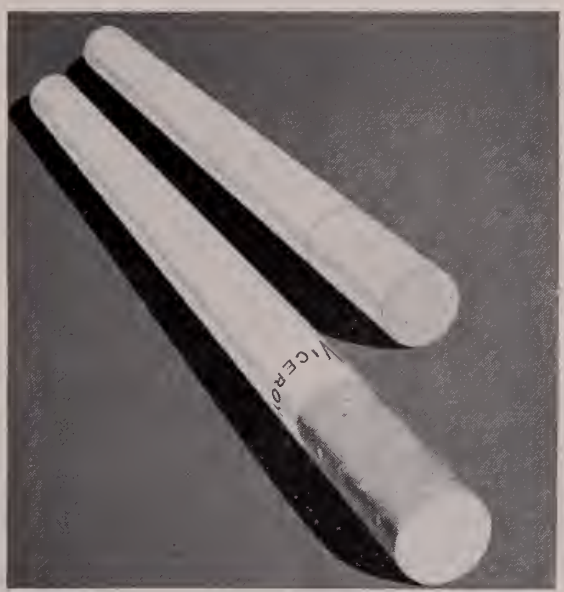


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SCHEDULE OF MEETINGS

ORGANIZATION	PRESIDENT	SECRETARY	ANNUAL MEETING
Medical Association	Frederick K. Herpel, W. Palm Bch.	Samuel M. Day, Jacksonville	
Medical Districts	John D. Milton, Miami	Council Chairman	
rthwest	Francis M. Watson, Marianna	George S. Palmer, Tallahassee	Marianna, 1954
rtheast	William C. Thomas Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, 1954
uthwest	Emmett E. Martin, Haines City	Clyde O. Anderson, St. Petersburg	Sarasota, 1954
utheast	Erasmus B. Hardee, Vero Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, 1954
Specialty Societies			
y of General Practice	Raymond R. Killinger, Jacksonville	Leo M. Wachtel Jr., Jacksonville	
Society	James H. Putman, Miami	Solomon D. Klotz, Orlando	
siologists, Soc. of	Adelbert F. Schrimer, Orlando	Breckenridge W. Wing, Orlando	
r, Am. Coll. Chest Phys.	Nathaniel M. Levin, Miami	Hawley H. Seiler, Tampa	
nd Syph., Soc. of	Morris Waisman, Tampa	Joseph A. J. Farrington, Jacksonville	
Officers' Society	Lorenzo L. Parks, Jacksonville	Clarence L. Brumback, W. Palm Beach	
ial & Railway Surgeons	Lloyd J. Netto, West Palm Beach	John H. Mitchell, Jacksonville	
gy & Psychiatry	William H. McCullagh, Jacksonville	Roger E. Phillips, Orlando	
Gynec. Society	Ferdinand Richards, Jacksonville	J. Champneys Taylor, Jacksonville	
l. & Otol., Soc. of	Mozart A. Lischkoff, Pensacola	Carl S. McLemore, Orlando	
edic Society	Herschel G. Cole, Tampa	Newton C. McCollough, Orlando	
gists, Society of	Alfred E. Cronkite, Fort Lauderdale	Clarence W. Ketchum, Tallahassee	
ic Society	C. Jennings Derrick, W. Palm Bch.	Wesley S. Nock, Coral Gables	
ogic Society	John J. Cheleden, Daytona Beach	George Williams Jr., Miami	
gical Society	Nelson T. Pearson, Miami	Hugh G. Reaves, Sarasota	
cal Society	Frank M. Woods, Miami	David W. Goddard, Daytona Beach	
—			
Science Exam. Board	Mr. Paul A. Vestal, Winter Park	M. W. Emmel, D.V.M., Gainesville	Gainesville, June 5, '54
l Banks, Association	James N. Patterson, Tampa	Sherman B. Forbes, Tampa	Jacksonville, May '54
Cross of Florida, Inc.	Mr. C. Dewitt Miller, Orlando	Mr. H. A. Schroder, Jacksonville	
Shield of Florida, Inc.	Leigh F. Robinson, Ft. Lauderdale	Webster Merritt, Jacksonville	
r Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	
al Diabetes Assn.	Fred Mathers, Orlando	Edward R. Smith, Jacksonville	Orlando, Oct. 21-22, '54
l Society, State	L. M. Schulstad, D.D.S., Bradenton	B. S. Carroll, D.D.S., Jacksonville	
Association	H. Milton Rogers, St. Petersburg	William P. Hixon, Pensacola	
tal Association	Mr. J. F. Wymer Jr., W. Palm B.	Mrs. Mary Reeder, Miami	
al Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
al Postgraduate Course	Turner Z. Cason, Jacksonville	Chairman	Jacksonville, July 12-16, '54
Anesthetists, Fla. Assn.	Miss Dorothy Jackson, C. Gables	Mrs. Lulla F. Bryan, Miami	
s Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
naceutical Association, State	Mr. A. W. Morrison, Miami	Mr. R. Q. Richards, Ft. Myers	Jacksonville, May 10-12 '54
Health Association	Frank M. Hall, Gainesville	Mr. Fred B. Ragland, Jacksonville	Miami Beach, Oct. '54
au Society	Lawrence C. Manni, Tallahassee	Simon D. Doff, Jacksonville	
culosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
n's Auxiliary	Mrs. Richard F. Stover, Miami		
n Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
n Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
a Medical Association	D. O. Morgan, Gadsden	Douglas L. Cannon, Montgomery	
Medical Assn. of	Wm. P. Harbin Jr., Rome	David Henry Poer, Atlanta	Macon, May 2-5, '54
spital Conference	Charles W. Holmes, Memphis, Tenn.	Pat Groner, Pensacola	
tern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
tern, Am. Urological Assn.	Russell B. Carson, Fort Lauderdale	Sidney Smith, Raleigh, N. C.	
tern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
st Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22, '54



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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	49
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	107
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	663
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	262
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	94
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	180
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	9
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	19
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	28
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	57
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	22
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	29
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	182
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	131
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	213
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	93
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	18
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	18
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	83
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
			Total,	2,560

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1. Cook, M. H.; Free, A. H., and Giordano, A. S.: Am. J. M. Technol. *19*:283, 1953.
2. Gray, C. H., and Millar, H. R.: Brit. M. J. *4824*:1361 (June 20) 1953.

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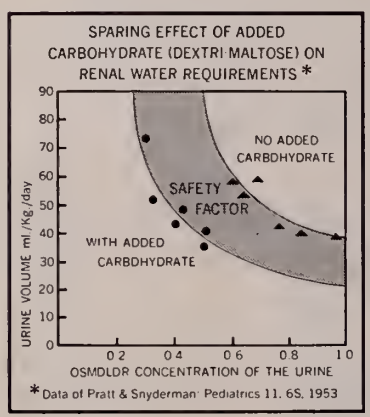
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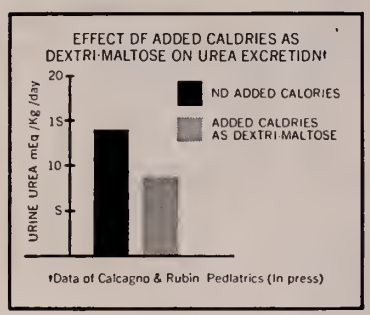
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1. Pratt & Snyderman: Pediatrics 11: 65, 1953; 2. Calcagna & Rubin: Pediatrics (in press); 3. Calcagna, Rubin & Weintraub: J. Clin. Investigation 33: 91, 1954; 4. Cooke, Pratt & Darrow: Yale J. Biol. & Med. 22: 227, 1950; 5. Gamble: J. Pediat. 30: 488, 1947; 6. Rappaport: Am. J. Dis. Child. 74: 682, 1947.

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OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XL JUNE, 1954 No. 12

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OCTOBER 11 - 15, 1954

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Frederick K. Herpel

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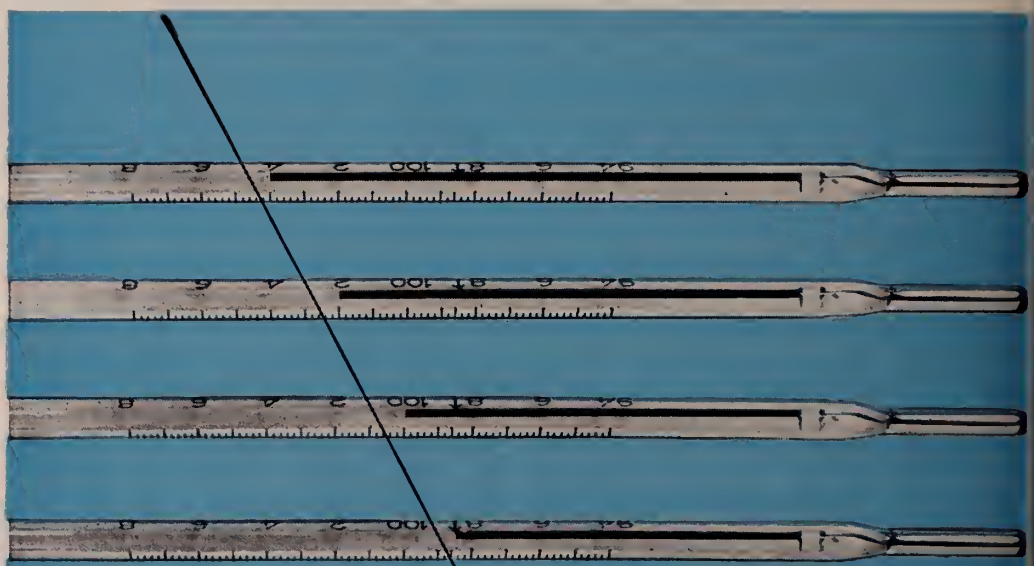
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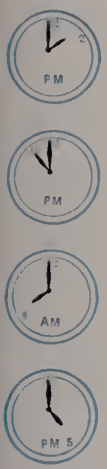


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English, A. R., et al.: Antibiotics Annual (1953-1954), New York, Medical Encyclopedia, Inc., 1953, p. 70.

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analysis
of present veteran population

AGE DISTRIBUTION (Exclusive of those discharged on or after June 27, 1950)

DATE	JAN. 1, 1952	JAN. 1, 1960	JAN. 1, 1970
TOTAL	18,850,000	18,160,000	16,146,000
AGE 22-44	77.2%	62.7%	13.5%
45-64	21.8%	27.4%	73.7%
OVER 65	1.0%	9.9%	12.8%

Older veterans are hospitalized more frequently for civilian-incurred ailments than for service-connected disabilities. By 1970, over 86% of the present veterans will be age 45 or over, more than three times the number in this older age group today. Because of advanced age, they will require more frequent and prolonged hospitalization for illnesses having no relationship to their military service. Responsibility for such medical care should be assumed by the individual or local government, not by the federal government.

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TO

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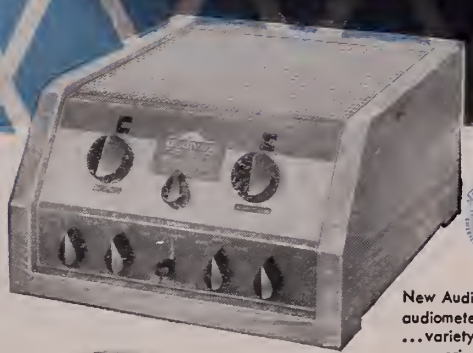
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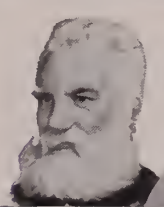
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1. Thorn, G. W., *et al.*, *New England J. Med.* **248**:632, April 9, 1953.

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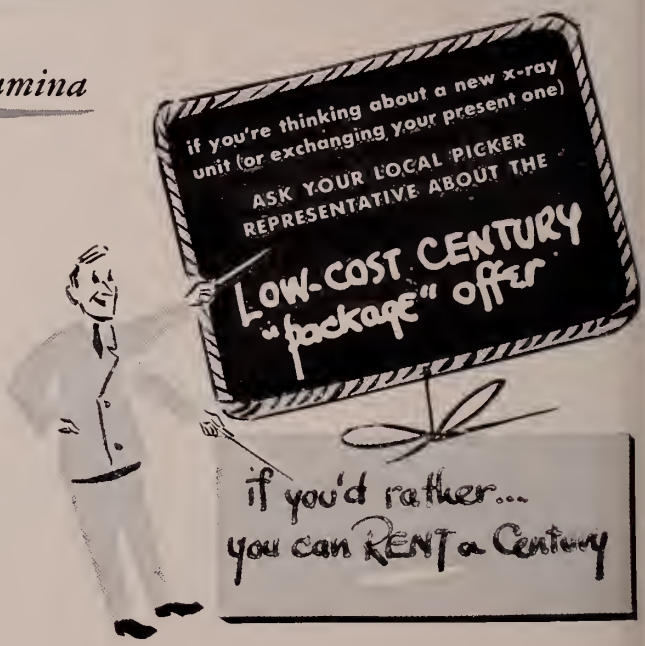
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*Stead, E. A., Jr., in Cecil, R. L., and Loeb, R. F.: Textbook of Medicine, ed. 8, Philadelphia, W. B. Saunders Co., 1951, p. 1065.

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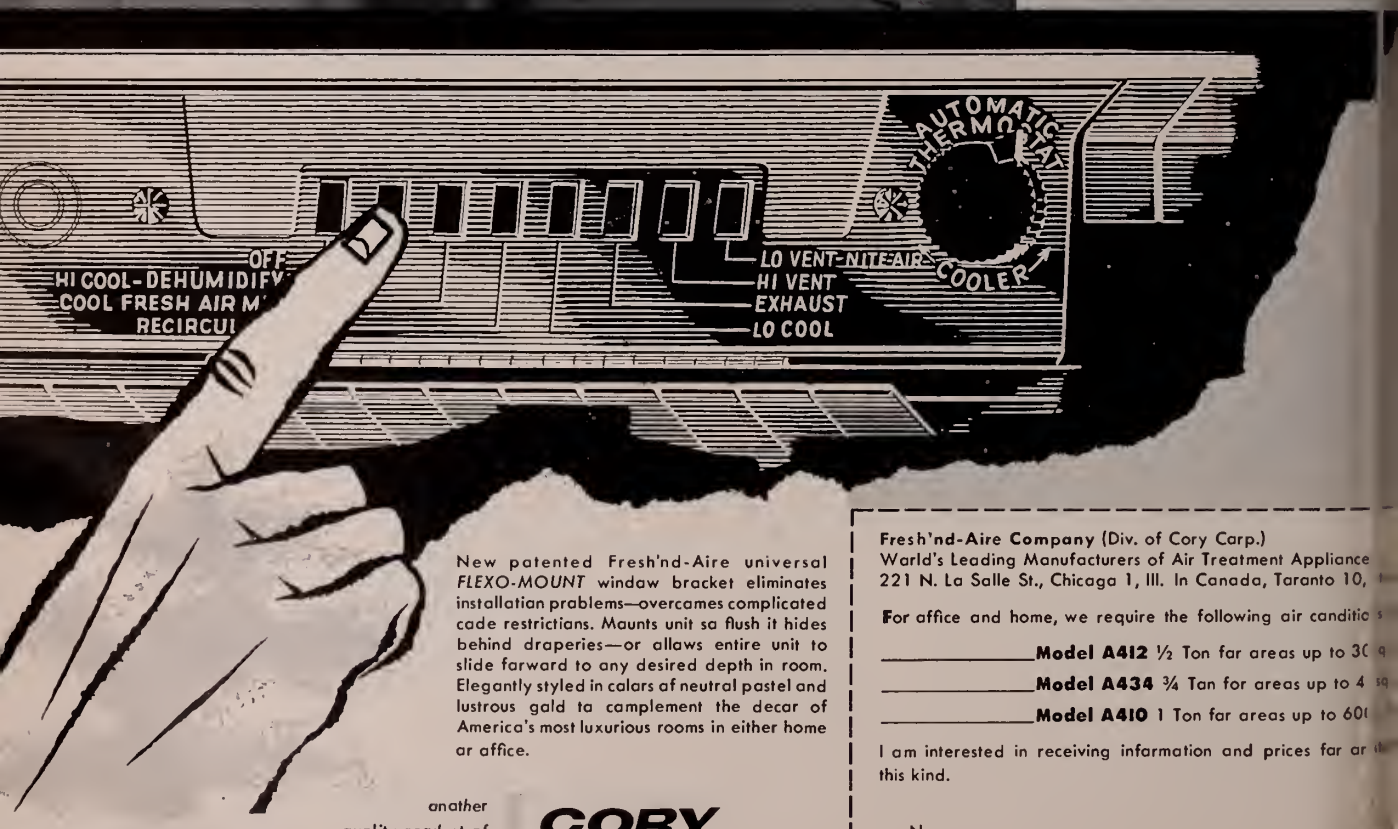
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WHEN SYMPTOMS ARE DISTRESSING BUT DISGUISED . . .

"It is strange," Malleson says, "how little clinical recognition" has been given to the "negative behavior" or "endogenous misery" of the woman with endocrine imbalance. Largely accountable for this, of course, is the patient's own reluctance to discuss these symptoms with her physician until she actually suffers from some of the more obvious menopausal symptoms such as hot flushes. Even then she may become so accustomed to her change in feeling she can't remember what it's like to feel well.[1]

Changes in the mood pattern are just a few of the many distressing symptoms of declining ovarian function which are so often disguised because they do not always coincide with cessation of menstruation, and at times will occur long before, and even years after. Other good examples are insomnia, headache, easy fatigability, arthralgia — and understandably so, when one considers that the loss of ovarian hormone "withdraws one of the most important metabolic regulators of the organism."[2]

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has no odor
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Estrogenic Substances (water-soluble), also known as conjugated estrogens (equine), available in both tablet and liquid form

1. Malleson, J.: Lancet 2:158 (July 25) 1953. 2. Goldzieher, M. A., and Goldzieher, J. W.: Endocrine Treatment in General Practice, New York, Springer Publishing Company, Inc. 1953, p. 23.

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3:15—Disintegration Test begins in actual stomach fluids (pH 2.7). Beaker at left contains ordinary enteric-coated erythromycin. At right is new *Film Sealed* ERYTHROCIN Stearate (Erythromycin Stearate, Abbott).

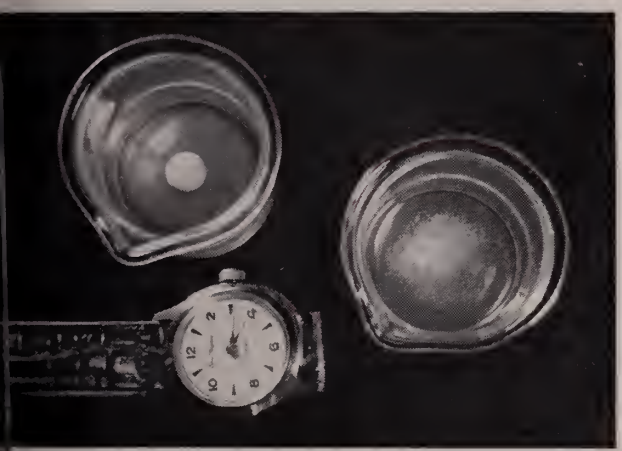
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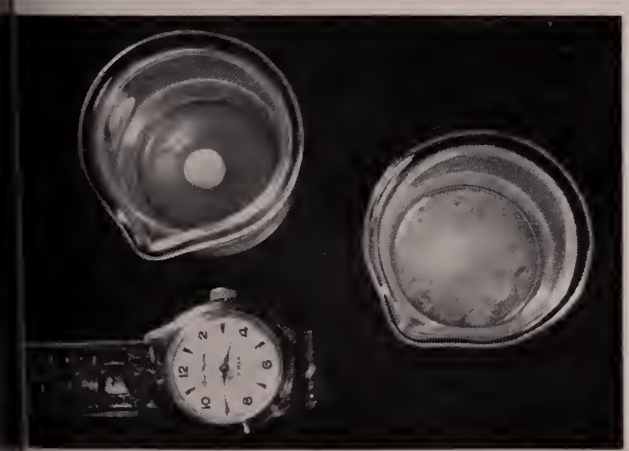
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:0—Five minutes later, *Film Sealed* coating has already rted to disintegrate. The tissue-thin film actually begins dissolve within 30 seconds after patient swallows tablet.



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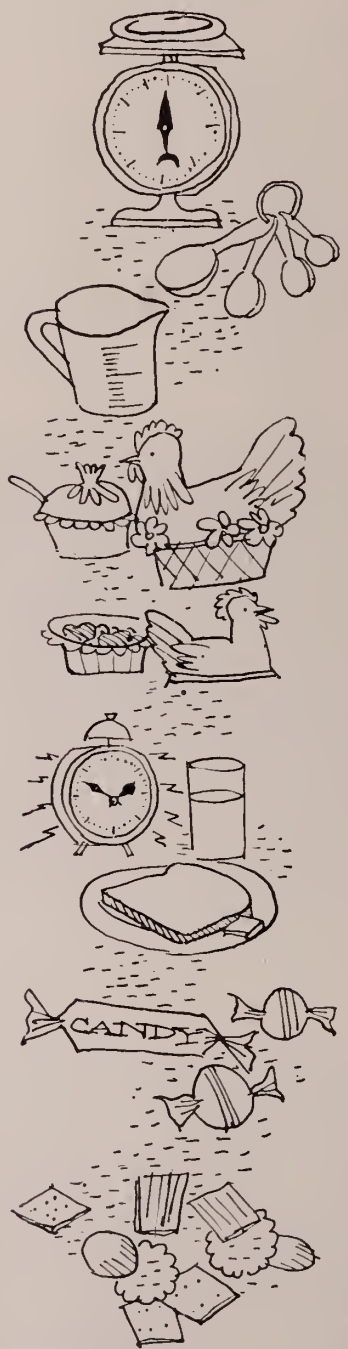
—Now the *Film Sealed* tablet mushrooms out with all of drug available for absorption. Note that enteric-coated t is still intact. Tests show that the new Stearate form itely protects ERYTHROCIN against gastric acids.



4:00—Because of *Film Sealing* (marketed only by Abbott) the drug is released faster, absorbed sooner. In the body, effective ERYTHROCIN blood levels now appear *in less than 2 hours* (instead of 4-6 hours as before).

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Making the Diabetic Diet fit...



Your patient may feel an outsider both at home and away from home when diabetes upsets his eating habits. Of course, a measured diet is vital. The trick is to fit that diet as closely as possible to the patient's personal preferences and way of life. Here are some diet "do's" to help in planning the menus.

At home—

Try to adapt favorite recipes to the diabetic diet. Then select vegetables, beverage, and fruit or dessert to complete the diet prescription for the meal.

Suggest that measured portions be served in dishes that fit the serving. A small portion on a large plate is not a happy prospect.

Where possible, let your patient use a food exchange list. He'll delight in the variations it provides.

Away from home—

Explain that insulin demands food with the urgency and regularity of an alarm clock. If a dinner party will be late, suggest a light snack at the usual mealtime with a corresponding caloric reduction in the delayed meal.

Allow extra carbohydrate for extra activity. And have your patient carry hard candies as a precaution against insulin reaction.

If possible, plan low-calorie wafers in the diet for times when others nibble canapés or chocolates.

A diet that fits in smoothly with your patient's family and social life means you'll have his fullest co-operation, and he'll lead a happier life.

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Beer—America's Beverage of Moderation

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— gives a zestful "salty" flavor to the sodium-restricted diet — helps to keep the patient on the salt-free regimen by making meals tasty.

Neocurtasal may be used wherever sodium restriction is indicated — it is completely sodium-free. May be used like ordinary table salt — added to foods during or before cooking or used to season foods at the table.

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Write for pad of diet sheets.

1. Heller, E. M.: The Treatment of Essential Hypertension. *Canad. Med. Assn. Jour.*, 61:293, Sept., 1949.

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rapid action . . .
short duration . . .
awaken refreshed

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No. 318	**1/2 gr. (0.0325 Gm.)**
No. 243	**3/4 gr. (0.05 Gm.)**
No. 240	**1 1/2 grs. (0.1 Gm.)**

DOSAGE:

Insomnia, 1 1/2 grs. Preoperative hypnotic, 3 to 4 1/2 grs. O. B., 3 to 4 1/2 grs. initially, followed by 1 1/2 to 3 grs. at one to three-hour intervals. Not more than 12 grs. in twenty-four hours.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XL | Jacksonville, Florida, June, 1954 | No. 12

President's Address

FREDERICK K. HERPEL, M.D.
WEST PALM BEACH

Mr. Vice President, Members of the House of Delegates, Distinguished Past Presidents, Members of the Florida Medical Association and Guests, Ladies and Gentlemen:

One year ago, on assuming the office of President of the Florida Medical Association, I felt a sense of inadequacy and uncertainty in the coming task of guiding the Association and acting as its leader. At that time I asked the members of this Association, the chairmen and members of the respective committees of the Association, and the officers and members of the Board of Governors to assist me in the performance of my duties, and sought their wise counsel and advice.

What progress has been made during the year has been in large part due to just that cooperation and help which you have so unselfishly given to me on every occasion. I wish to pay tribute to the members of the Board of Governors for their faithful attendance at meetings of the Board, for their assumption of special assignments, and for their continued wise advice on matters of policy.

I am also deeply indebted to the personnel of the Executive Office in Jacksonville, who, under the capable direction of Mr. Ernest R. Gibson, Acting Managing Director, have so ably performed the functions of the office of the Association. The proximity of our genial and hard working Secretary, Dr. Samuel M. Day, to the Executive Office, has contributed to the dispatch of routine matters without delay. The work of the Executive Office has been most efficiently handled. The Public Relations Bureau, under direction of the Board of Governors with Dr. Edward Jelks acting as liaison officer between the Board and the Public Relations Bureau, has, under Mr. W. Harold Parham, Supervisor, made significant strides forward in improvement of our public relations, and has kept us in close touch with the public relations activities of the American Medical Association. Mr. Tom Jarvis, Assistant Supervisor, has also contributed materially to this activity.

The officers of the Association are deeply indebted to Dr. J. Rocher Chappell for his continuance as chairman of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, when it became evident that a choice of his successor would be difficult. Dr. John D. Milton, serving as chairman of the Council and chairman of the sub-committee to the Board of Governors on Review of Fee Schedules, as well as serving as a member of the Board, has performed an outstanding service to the Association. The continuing activities of the sub-committee on Insurance, under the chairmanship of Dr. Day, have required many hours of work on the part of this committee, whose members are not yet ready to make their final report to the Association. Dr. Leigh F. Robinson has functioned, as always, most efficiently as a sub-committee of the Board on Blue Shield activities. The work of the Committee on Scientific Work, under Dr. Jere W. Annis, is reflected in the scientific presentations which you will enjoy during this convention. The activity of the Committee on Medical Economics, under Dr. Reuben B. Chrisman Jr., has been continuous and productive of much good to the Association and its membership.

Read before the Florida Medical Association, Eightieth Annual Meeting, Hollywood, April 27, 1954.

The sub-committees to the Board of Governors on Veterans Care and on Advisory to National Foundation for Infantile Paralysis, under the chairmanship of Dr. Frederick H. Bowen, have also made significant contributions to the Association during the year. I should like to recognize the activity of Dr. Frazier J. Payton on the Florida Cancer Council, arising from his selection to the Council from the Committee on Cancer Control. The work of the Committee on Medical Education and Hospitals, under the chairmanship of Dr. Jack Q. Cleveland, while consisting largely of investigation of matters referred to the Committee from the Board of Governors, has been continuous throughout the year, and has rendered most valuable assistance to your Board of Governors.

Lastly, I wish specially to commend the Committee on Legislation and Public Policy, under the chairmanship of Dr. H. Phillip Hampton, which has functioned so continuously throughout the year. Through the watchfulness of this Committee the attention of your Board of Governors, and the membership of the Association, has been directed to matters concerning pending and proposed legislation, both on the national and at the state level. Added support of the work of this Committee by the membership at large, and particularly by the legislative committees of the respective county medical societies, must be obtained if any success attends our efforts to influence legislation, particularly at the state level. Despite the fact that a session of the Florida Legislature does not meet this year, the activities of this important Committee must now become continuous, with an early determination with respect to proposed legislation to be introduced or supported at the meeting of the legislature in 1955. Local legislative committees should keep in close touch with the chairman of this Committee.

There has been such a general willingness to assume responsibility, and to undergo travel and loss of time from practice, on the part of so many members of the Association that selection of a few for special mention may seem unfair to many others. When one remembers that travel is performed without compensation or remuneration, and that time lost from practice cannot be made up, service to the Association assumes an importance which cannot be measured by words of appreciation.

Executive Office

Reassignment of duties and functions among the personnel of the Executive Office, the addition of time-saving and labor-saving equipment, and redecoration and air-conditioning of the offices have resulted in a high level of performance by the personnel employed in these offices, and excellent morale. Only those physicians who have visited the offices of the Association in Jacksonville can appreciate the volume of work which is handled there, and the manner in which matters are expeditiously handled and disposed of by final action or reference.

Public Relations

Public Relations activities of the Association's staff, operating under direction of the Board of Governors, and with the liaison mentioned, have been continued intensively throughout the year. Substantial progress has been made along all lines. Mr. Parham has attended many meetings, national, regional and statewide, on Public Relations matters. Members of the Board of Governors, and your officers, have also attended similar meetings. There has resulted much improved correlation of activities throughout the state.

The public forums on medical subjects, originating, as you well know, with the Pinellas County Medical Society, have now become a part of the Public Relations program in many county medical societies in Florida, and the plan is spreading to other states as well. These forums are assuming increasing importance in improving our relationships with the people whom we serve. It is impossible to separate such forums from publicity. Care must be exercised that the publicity is directed toward the public service feature of these forums, and not to the elevation of certain physicians in the community in the eyes of the public. In connection with the appearance of physicians on radio and television programs, and in their relations with the press, your attention is invited to the suggested basis for a Code of Cooperation, on the local level, which outline was recently forwarded to the societies from the Executive Office.

Postgraduate Medical Education

In a recent President's Page in The Journal mention was made of the tendency of hospital staffs to take over the function of the county medical society with respect to scientific pro-

grams. Recent changes in staff procedure will likely see a decrease in this activity and a return to the scientific program feature of the county society meetings. Carefully arranged and planned scientific programs, given by members of the society or by invited guest speakers, can keep the membership well informed concerning advances in medicine and surgery, and the changing aspects of medical care. Our well conducted and planned annual postgraduate Short Course, so ably directed by Dr. Turner Z. Cason, we hope will be continued.

Recognition is extended to the University of Miami School of Medicine, now completing its second year of instruction in medicine. The excellent cooperation of the medical profession in Miami and Dade County has made possible the establishment of this, the first medical school in Florida. I bespeak for this, the youngest of our medical schools, your earnest support and continued interest. The proposed erection of a state-supported medical school in connection with the University of Florida, at Gainesville, should in no way conflict with the University of Miami School of Medicine. The need for trained physicians will increase each year, and the expected number of graduates from two schools of medicine will not meet the annual need for replacements created by retirement from practice and death among the physicians in Florida.

Prepaid Medical and Hospital Insurance

It is noteworthy that an increasing number of persons in Florida are being protected against unusual medical and hospital bills by some form of prepaid insurance. One must concede that the coverage obtainable under the present premiums does not coincide with what the average person has been led to expect from his insurance. Few bother to read the details of their insurance plans. Complete coverage cannot be offered with the present scale of premiums. Education of the public, and of physicians, will be necessary before complete coverage for illness can be made available for those who need it. I am not convinced that governmental reinsurance is the solution.

Veterans Care

Recent action of the House of Delegates of the American Medical Association again emphasizes the opposition of organized medicine to further extensions of federal care of veterans suffering from non-service-connected disabilities and diseases. In taking this position we are outnumbered by the huge veterans population. You should all know that organized medicine has always been in complete accord with the provision of the finest obtainable medical, surgical and hospital care for veterans suffering from service-connected diseases and disabilities. The present shortage of hospital beds, under control of the Veterans Administration, for the care of veterans suffering from tuberculosis, and from nervous and mental diseases, is largely due to the fact that a large proportion of the hospital beds are filled with veterans suffering with non-service-connected disabilities and diseases. Whether we admit Socialized Medicine by the front door, or have it enter through other devious and concealed entrances, while we stoutly maintain opposition to it in any and all forms, matters little when the fact of this entrance has been accomplished. The signs have pointed, and are still pointing, toward an increasing domination of medical practice by the State, despite statements to the contrary. Bureaucracy is insidious, and determined, in its invasion of and encroachment on business and profession. We stand with the lawyer, the dentist, the farmer and the small business man in our opposition to domination by the State, but we are in the minority politically. We do not need to take our medicine lying down, though I fear we are just a little sick.

Woman's Auxiliary

I wish to pay tribute to the excellent work of the Woman's Auxiliary under the capable and inspiring leadership of Mrs. Thomas C. Kenaston. A widening emphasis on training for activity has characterized the work of the Auxiliary. The presence of Mrs. Kenaston at workshops held in connection with the District Meetings in October was, I believe, of considerable value to the working auxiliaries.

Medical Organization

The American Medical Association is your parent organization, and it could not exist without you. Through the activities of its officers, councils and committees, and of its House of Delegates, decisions are reached on broad policies which appear to represent the wishes of the majority of physicians. But from this point the implementing and carrying out of determined policies rests with the basic unit of organized medicine, the county medical society and its

membership physicians in practice. The cooperation and sustained interest of the physician are a part of his contribution to the welfare and advancement of medical practice, and toward improved relationships between the physician and the hospital, and the public they both serve. Some of the county societies are splendidly organized for this work, while others need further organization and work to reach a satisfactory level of performance.

May I comment briefly on the District Meetings of the Association, held each fall in the four Medical Districts? The very considerable sacrifice of time, and of travel, on the part of your officers and certain committee chairmen, affording you an opportunity to meet with them and discuss, between conventions, matters of importance to them and to you, would seem to lead to a recognition by you of the importance of these meetings. The attendance and interest at last fall's meetings did not, in some instances, reflect such an opinion. Many of the physicians whom we should like to reach do not attend. The faithful few are always to be counted upon, but they, in large measure, know what this is all about and are already pulling more than their fair share of the load of work and travel. Perhaps better local organization of these District Meetings is the answer. The suggestion has been made that round table discussions might be of interest in connection with these meetings, with competent leadership in discussions concerning your local society problems, as well as medical problems on the state level.

You should all be aware now that an important meeting of the American Medical Association, the Clinical Session in the fall of 1954, will be held in Miami November 29 through December 2. This is the first time that any meeting of the American Medical Association has been held in Florida, and the first time such a meeting has been held in a city where there did not exist an established four year medical school. The general chairman of this Clinical Session is our own past president, Dr. Homer L. Pearson Jr. of Miami, now a member of the Judicial Council of the American Medical Association. The burden of organization for this clinical session will rest largely upon the membership of the Dade County Medical Association. Dade County is splendidly organized for the carrying out of this assignment. That they will succeed, and perfect an outstanding program, is to be expected. The complete cooperation and wholehearted support of every member of the Florida Medical Association is requested in connection with this meeting. You will be called upon to help at the proper time, and your expressed willingness to help and be of service will be greatly appreciated by the General Chairman and by the Dade County Medical Association and its fine membership. I urge that you now acquaint yourselves with the details of this meeting, and make your plans to attend.

Annual Meeting

Again your President wishes to call to your attention the fact that there are few satisfactory meeting places for a convention of this size, and with its peculiar requirements for space. Careful restudy has been made of available and possible sites for future meetings of the Association. We have been aware of the increasing sentiment throughout the Association seeking another place for our annual convention. It has been evident to all of us who have been concerned with obtaining the best place for this convention that this hotel has offered the best facilities, year after year. Shortly it should be possible to hold our annual meetings in other sections of the state. We could now meet in Miami, which has satisfactorily accommodated larger medical conventions than ours, but there is little choice, so far as expense and travel are concerned, between meeting in Hollywood and in Miami. You are again reminded, though just now this may not seem important to you, that if we relinquish our present dates with this hotel, we may not be able to return here at a suitable date in the future. The demand, on the part of regional, national and state organizations, for a meeting place such as this, far exceeds the supply. This condition is not unique in Florida. All other rapidly growing organizations are experiencing similar growing pains, and have similar problems in obtaining adequate convention facilities.

Our Delegates to the American Medical Association

I would be remiss if I did not publicly recognize, and thank, our Delegates to the American Medical Association, past and present, for their excellent service. Our present representation on the Judicial Council, on the Council on Medical Service, and on the Committee on Legislation has been a deserved recognition of our representatives.

Florida medicine has gained in stature through the outstanding service of Drs. Homer L. Pearson Jr., Louis M. Orr, Reuben B. Chrisman Jr., and Herbert L. Bryans.

The Journal

I bespeak for the Editor of The Journal and his efficient staff your earnest support. Read in the June issue the report of your Editor. Your Journal rates high among the state medical journals. The editorial staff has given you, throughout the year, some stimulating ideas and discussions. I hope that you have all read them. The quality of The Journal is always being improved, but the Editor needs the help you can render by furnishing articles for The Journal and items of local or state interest with regard to physicians, hospitals, and county society activities. This is your Journal, and it reflects your support and interest.

Growth of the Association

The membership of the Association on Dec. 31, 1952, was 2,313. On Dec. 31, 1953, it was 2,466, showing a net increase in membership of 153. This is about the average net increase for the past several years. At the same time Florida physician memberships in the American Medical Association increased by 180, entitling us to three representatives in the House of Delegates of the American Medical Association now that we have over 2,000 A.M.A. members. You all know how rapidly the population of Florida is increasing. There should be no surprise that the number of physicians practicing in the state is keeping pace with this population increase.

In closing may I express to each one of you who have worked with me this year my deep appreciation for the quality and extent of your services to the Association? It has been a year of pleasure to me to have been permitted to serve you as President. To the members of the Association my thanks again for the honor you paid me two years ago in electing me to the office of President-elect. The past two years of service have been fruitful ones, and have made it possible for me to become acquainted with the many fine physicians of Florida. To the Florida Medical Association my best wishes for the continued advance of medicine in Florida through my successors in office. I am now approaching the status of past president, joining a group of distinguished former presidents, without whose advice and counsel I would not have been able to serve you as you had a right to expect.

To my associate in practice, Dr. Russell D. D. Hoover, who has so willingly and cheerfully carried on my work when I was away from the office and hospital, I again publicly express my thanks for making this year of service possible.

To my beloved wife, who has accompanied me on some of my trips within and without the state, but has often kept the home fire burning until my return, I can only say, "Without your encouragement and trust in me, little could have been done. Thank you for your love and understanding."

To all of you "God Bless You and Keep You." May this Association, under succeeding leaders, reach new and higher peaks of achievement, as we increasingly make available to the people of Florida and to those who visit with us, the high quality of medical and surgical care of which we are capable, and which they have a right to expect from us.

THE EIGHTY-FIRST ANNUAL CONVENTION
of the
FLORIDA MEDICAL ASSOCIATION
ST. PETERSBURG APRIL 3-6, 1955
Headquarters: Vinoy Park Hotel

CONVENTION HIGHLIGHTS













PROCEEDINGS

Eightieth Annual Meeting

of the

FLORIDA MEDICAL ASSOCIATION

Held at HOLLYWOOD

APRIL 26, 27 and 28, 1954

GENERAL SESSIONS

First General Session

The Eightieth Annual Meeting of the Florida Medical Association was called to order at 9:30 a.m., Monday, April 26, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Florida, by President Frederick K. Herpel.

Invocation was pronounced by The Reverend Harold C. Williamson, Rector, St. Johns Episcopal Church, Hollywood.

Almighty God, Father of all mankind, who art the fountain and source of all knowledge, skill and healing; graciously behold and bless this convocation of doctors, physicians and surgeons of the Florida Medical Association here assembled. As thou hast called them to thy merciful mission of healing, so grant to them a special measure of thy grace and the divine companionship of thy Holy Spirit in the treatment and cure of thy suffering children. We especially implore thy blessing upon all medical research, and that thou wouldest be pleased to reveal to us yet more and more of thy healing and life-giving wisdom. Overshadow, O most loving Father, the proceedings of these meetings, and grant that these thy servants may be so inspired and illuminated by all that may here transpire that they may go forth with renewed zeal and dedication to that vocation of healing wherewith thou has called them. Bless the homes and communities in which these thy servants dwell, and fill thy servants with thy wisdom and strength as they go about healing the sick, even as thy Son, the Great Physician in whose Name and for whose sake we offer this our prayer. AMEN.

Dr. Herpel: "Dr. Edward W. Cullipher, President of the Dade County Medical Association, will deliver the address of welcome."

Dr. Cullipher: "Mr. President, delegates, members and guests, it is a distinct pleasure for me to extend to you the greetings of the Dade County Medical Association, your official host for the 1954 annual meeting.

"Standing here today it seems as if I can still hear the echo of Bob McIver's gavel closing last year's meeting. Time passes too fast for all of us these days. I am sure that our committee chairmen and the members who have helped them, realize this more than most of us. The year's work hardly begins before it is over and we must think of next year. So it has been for eighty years. That first organizational meeting must have been a momentous task.

"The progress reports we will hear rendered in the sessions now before us will speak for the achievements made during your administration, Mr. President, and I do not feel it my prerogative to steal from the committee chairmen the privilege of telling the members of the many things

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Convention Highlights (Opposite)

Top left, Association Secretary-Treasurer Samuel M. Day, Jacksonville; right, President Duncan T. McEwan of Orlando is escorted to the rostrum by Drs. Walter C. Jones of Miami (left) and Louis M. Orr of Orlando.

Center left, President-elect John D. Milton of Miami, President McEwan, and Outgoing President Frederick K. Herpel of West Palm Beach; right, Dr. McEwan presents past president's button to Dr. Herpel.

Bottom left, Dr. Milton is congratulated by Dr. Herpel; right, Dr. Herpel introduces the guest speaker, Dr. Wilburt C. Davison of Durham, N. C., Dean of the Duke University School of Medicine.

which have been done as a result of the various meetings held on Sundays during the past twelve months.

"The older members of the Florida Medical Association may look with pride at the organization they have helped to mold into the fine product which now represents us in the eyes of the public. I feel certain that we young fellows will look back some day to the constructive action taken by the group assembled here today. We all know too well the public and governmental scrutiny to which we are subjected; therefore, we must recognize our shortcomings wherever they exist and take immediate steps to remove these obstacles to our progress. In the long run the Association is paramount, problems are incidental.

"Once again, may I offer you a warm welcome from D.C.M.A., with a hope that you find this the most enjoyable meeting yet. In closing, a word of warning — let us each remember that overexertion in debate in the daily meetings should not in any way be allowed to interfere with the important business sessions which are planned.

"Thank you."

Dr. Herpel: "Thank you very much, Dr. Cullipher, for your cordial words of welcome on behalf of the Dade County Medical Association."

"I would now like to introduce the fraternal delegates from Georgia, Dr. J. W. Chambers of LaGrange and Dr. R. M. Joiner of Moultrie."

Dr. Chambers was present and was recognized.

Dr. Chambers: "I would like to say that we, the one hundred and four year old Medical Association of Georgia, extend our greetings to this Eightieth Annual Session of the Florida Medical Association. I also bring to you and your Association the personal greetings of Dr. Wm. P. Harbin Jr., our president."

Dr. Herpel: "We will have delegates at your meeting in Macon in May. I have had the pleasure of meeting your president at some of our regional meetings."

There being no further business, the meeting adjourned on motion, duly seconded at 9:40 a.m.

Second General Session

The Second General Session of the Florida Medical Association convened at 11:35 a.m., Tuesday, April 27, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood; President Herpel in the Chair.

Dr. Herpel: "One of the privileges and pleasures of serving as President of this Association, is the opportunity to extend to some outstanding physician or surgeon, the invitation to present to us a guest oration on some phase of medical or surgical practice, or some subject which is directly related to the practice of medicine. Such has been my privilege and my honor. The gentleman I am about to present to you is a distinguished physician, one whom I have not known well personally, but have known by reputation for many years. He was a Rhodes Scholar at the time of the beginning of the first World War, he served with the British forces, then came back to Johns Hopkins, where he received his medical degree in 1917. I believe he returned overseas for further service.

"For many years he has been an educator and has been a dean and professor of one of our Grade A medical schools. It has been a pleasure, through the years, to follow his progress in medical education, the many services which he has rendered to organized medicine in the field of education and to the Federal government and its agencies in many capacities.

"It is my pleasure to introduce to you as your guest speaker, Dr. Wilburt C. Davison of Durham, North Carolina, an internist, a distinguished pediatrician, Dean of the Duke University School of Medicine, and John P. Duke Professor of Pediatrics at that institution."

Address: "Changes in Medical Education and Patient Care," by Dr. Davison.

Dr. Herpel thanked Dr. Davison for his address and for the interest manifested in the meeting of the Association.

Dr. Herpel: "At this time, we are pleased to grant time for the presentation of an award to Dr. Bascom Palmer of Miami. This award will be made by Mr. Claud Andrews, Director of Vocational Rehabilitation in Florida.

Mr. Andrews: "Dr. Herpel, Dr. Davison, Members of the Florida Medical Association: I would like to request that Dr. Bascom Palmer come forward, please."

Dr. Palmer came to the rostrum.

Mr. Andrews: "Some ten years ago, Congress enacted a law which set aside the first week in October as National Employ the Physically Handicapped Week. A committee was appointed by the President of the United States and one of the privileges of this committee is the presenta-

tion of citations to certain individuals for outstanding service in the work of employing the handicapped. The individuals so honored, are selected first by their local committees, then by the state committee, and the recommendations of both committees are sent to the national committee in Washington, D. C.

So today, it gives me great pleasure to present to a member of your group, this citation for outstanding service. I know you know a great deal more about Dr. Palmer than I do, but Dr. Palmer is being honored today for the great work that he has done with the blind in Miami. I have a letter written by the people with whom he has worked, those who operate the Miami Lighthouse for the Blind. Dr. Palmer, it gives me great pleasure to present to you, this citation from the President's Committee of the National Employ the Handicapped Week for outstanding service."

Dr. Palmer: "Mr. Andrews, President Herpel, Dr. Davison, ladies and gentlemen: My weakness of voice is not due entirely to the emotion I feel, deep as it is. I am sure that all of you, who have received distinctions, are well aware of the fact that none of us ever deserves them by his own efforts alone. I am sure there is given too much credit for what I have been able to accomplish in our Miami Lighthouse for the Blind. Our progress has been due to the consecrated efforts of all those workers. As one worker, I am very proud of the work which the state of Florida is doing for the rehabilitation of the handicapped. I am more familiar with the work of the Florida Council for the Blind and our own association of workers for the blind through our Miami Lighthouse than I am with any other. Although Florida has a larger percentage of blind people than any other state, I am sure it is not all attributable to the shortcomings of our ophthalmologists. We have a larger percentage of blind because they come into our state from other states because of our pleasant living conditions.

"You will be delighted to know that the Florida Council for the Blind, in just ten years of existence, is now rated by the national government as one of the finest in the country, certainly within the top three or four.

"As to our local situation, I think they are planning wisely and soundly. It has been the hope that some day we could build a building and become a part of the great medical center which is developing in our midst and that we would develop a fine ophthalmological institute. Now, there are a great many drives for money (and as Dr. Davison said, almost anything can be accomplished if you have proper finances). This institute has resolved not to go off 'half-cocked,' so they have acquired a piece of property and they have over $100,000. It will not be begun until all funds are at hand so that we will not have to be adding to your burdens by continued begging. We believe it can be integrated so well with the new medical center that there will be no friction, since it is being properly planned.

"Again, Mr. Andrews, I wish to thank you for your very splendid citation, which I shall accept, not as a personal tribute, but on behalf of all those in the medical profession who are interested in rehabilitation of the handicapped."

There being no further business, the second general session adjourned at 12:15 p.m.

1954 MEDICAL DISTRICT MEETINGS

"A" Marianna	October 11
"B" Sanford	October 13
"C" Sarasota	October 15
"D" Vero Beach	October 14

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:35 a.m., Tuesday, April 27, 1954 in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Florida, with Dr. Frederick K. Herpel, President, in the Chair.

Dr. Louis M. Orr, Chairman of the Credentials Committee, announced that a quorum was present. (Subsequent report of the Credentials Committee showed 127 delegates registered.)

Dr. Herbert E. White moved that the delegates be seated.

Seconded by Dr. John D. Milton.

Motion carried.

Delegates

ALACHUA—F. Emory Bell, Henry J. Babers Jr.
BAY—William C. Roberts
BREVARD—*(Absent—Gerard E. Christie)*
BROWARD—Fred E. Brammer, Burns A. Dobbins Jr., Donald H. Gahagen, Richard A. Mills, Curtis H. Sory
COLUMBIA—Laurie J. Arnold Jr.
DADE—Ralph F. Allen, James L. Anderson, Turner E. Cato, Reuben B. Chrisman Jr., Jack Q. Cleveland, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Richard M. Fleming, James W. Holmes, R. Spencer Howell, Ralph W. Jack, Walter C. Jones, Robert P. Keiser, Alfred G. Levin, Donald F. Marion, John D. Milton, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson Jr., Frederick P. Poppe, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, Leonald L. Weil
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—Jackson L. Allgood Jr., Frederick H. Bowen. Hugh A. Carithers, Turner Z. Cason, Karl B. Hanson, Edward Jelks, F. Gordon King, Raymond H. King, Thomas H. Lipscomb, Joseph J. Lowenthal, Wilson T Sowder, Sidney Stillman, G. Dekle Taylor
ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.
FRANKLIN-GULF—Albert L. Ward
HILLSBOROUGH—Leffie M. Carlton Jr., C. Frank Chunn, Herschel G. Cole, Joshua C. Dickinson, H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., William M. Rowlett, J. Maxwell Williams Jr.
INDIAN RIVER—John P. Gifford
JACKSON-CALHOUN—Grayson C. Synder
LAKE—C. McK. Tyre
LEE-CHARLOTTE-COLLIER-HENDRY—William H. Grace, Baker Whisnant
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Julius C. Davis, T. Bert Fletcher Jr., Francis T. Holland
MADISON—Harry A. Nevel
MANATEE—Millard P. Quillian
MARION—Eugene G. Peek Jr.
MONROE—Ralph Herz
NASSAU—Cecil B. Brewton
ORANGE—Frank C. Bone, David Y. Hicks Jr., Edgar E. Hitchcock, Walter B. Johnston, Carl S. McLemore, Louis M. Orr, Adelbert F. Schirmer, Charles R. Sias
PALM BEACH—Thomas E. Daly, C. Jennings Derrick, Graham W. King Jr., V. Marklin Johnson, Ralph M. Overstreet Jr., Cecil M. Peek
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—William M. Davis, N. Worth Gable, Francis H. Langley, Norval M. Marr, James H. Miller Jr., Alvin L. Mills, Richard Reeser Jr., John P. Rowell, Rowland E. Wood
POLK—Jere W. Annis, Samuel J. Clark, Ivan W. Gessler, Marion W. Hester
PUTNAM—*(Absent—Lawrence G. Hebel)*
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—John T. McDermid
SARASOTA—John M. Butcher, Melvin M. Simmons
SEMINOLE—*(Absent—John M. Morgan)*
SUWANNEE—Edward G. Haskell Jr.
TAYLOR—Ralph J. Greene
VOLUSIA—C. Robert DeArmas, Peter A. Drohomer, Herbert A. King, Joseph H. Rutter
WALTON-OKALOOSA—*Absent—(Arthur G. Williams Sr.)*
WASHINGTON-HOLMES—*(Absent—Martin L. Lane)*
STATE OFFICERS—Frederick K. Herpel, Duncan T. McEwan, Thomas H. Bates, Russell B. Carson, Thomas C. Kenaston, Samuel M. Day, Shaler Richardson

On motion by Dr. Burns A. Dobbins Jr., seconded by Dr. Reuben B. Chrisman Jr., the minutes of the Seventy-Ninth Annual Session as published in the June 1953 Journal were approved.

President Herpel asked Dr. Thomas H. Bates, First Vice President, to take the Chair.

Dr. Bates: "Members, the prerogative of office falls to the First Vice President for a very brief moment; that moment has now arrived. It is my pleasure and privilege to present to you a man who, throughout the past year, has so ably served this organization. Long before he became President of the Florida Medical Association, he worked with many of you on committee work and has done an outstanding service for organized medicine.

"One of those transplanted Florida 'Crackers' from Pennsylvania, a graduate of Johns Hopkins, a retired officer of the United States Army, a distinguished citizen of West Palm Beach, it is my pleasure and privilege to present to you, the President of the Florida Medical Association, Dr. Frederick K. Herpel."

Dr. Herpel delivered his presidential address. (The complete text may be found in this Journal on page 887.)

At the close of the address, the members stood in unison and gave extended applause.

Dr. Bates: "President Herpel, the standing vote of approval and prolonged applause bespeak the wholehearted approval of the membership of this Association for the excellent work you have done in the past year."

President Herpel resumed the Chair.

President Herpel called for nominations for two delegates and two alternates to the House of Delegates of the American Medical Association.

The Chair recognized Dr. Eugene B. Maxwell of Hillsborough.

Dr. Maxwell: "Delegates, members, ladies: Two years ago, the delegates of the Florida Medical Association saw fit to send as our representative a man who has made an outstanding record and a man of whom Florida can be proud. At the first session he attended, he was named to the Legislative Committee. At the second, he was named to a Reference Committee. I don't have to tell you anything about this man, you all know him, and he has done an outstanding job. It gives me great pleasure to place in nomination to succeed himself, the name of Dr. Reuben B. Chrisman Jr. of Miami."

The Chair recognized Dr. Ralph S. Sappenfield of Dade.

Dr. Sappenfield: "We, of the Dade County Medical Association, take pleasure in seconding the nomination of Dr. Reuben B. Chrisman Jr. for delegate to the A.M.A. because he has done a great job in a short time, and has the ability, drive and enthusiasm to do an even better job."

Dr. Herbert E. Bryans: "I move that nominations be closed and the secretary cast a unanimous ballot for Dr. Chrisman."

Seconded by Dr. Walter C. Payne Sr.

The President asked for a rising vote, which was unanimous.

The Chair recognized Dr. Homer L. Pearson Jr. of Dade.

Dr. Pearson: "I would like to nominate a person who has served long and well as an alternate. It is like being always a bridesmaid, never a bride. Frank Gray was alternate for me for about ten years, and has been serving about two years for Chris. I would like to continue him in office and place in nomination the name of Dr. Frank D. Gray of Orlando."

Seconded by Dr. Ralph Herz.

Dr. Adelbert F. Schirmer: "I move that nominations be closed."

Seconded by Dr. C. Jennings Derrick.

The Secretary cast a unanimous ballot for Dr. Gray.

The Chair recognized Dr. Herbert L. Bryans of Escambia.

Dr. Bryans: "I would like to take this opportunity to express my thanks to this group for the many honors that you have conferred upon me over the years. I am most deeply appreciative of those honors. I have attempted to serve to the best of my ability.

"At this time, it is my pleasure and privilege to nominate a man who, over a period of years has served on many committees, served on the Board of Governors, and has never by-passed any assignment. At the present time, he is a member of the medical advisory committee to the Florida Crippled Children's Commission, he is also alternate delegate and is First Vice President; and it gives me great pleasure to nominate Dr. Thomas H. Bates of Lake City."

The Chair recognized Dr. Carl S. McLemore of Orange.

Dr. McLemore: "I would like to nominate Dr. Francis T. Holland of Tallahassee."

Dr. Alvin L. Mills: "I move that the nominations be closed."

Seconded by Dr. Sidney G. Kennedy Jr.

Motion carried.

The Chair ruled that a secret ballot was in order and appointed Drs. Eugene G. Peek Jr., Thomas E. Daly and C. Robert DeArmas as tellers.

Dr. Herpel read the personnel of the three reference committees, as follows:

1. HEALTH AND EDUCATION
   Television Room
   John D. Milton, *Chairman*
   Jere W. Annis
   G. Dekle Taylor
   C. Frank Chunn
   Francis T. Holland
2. PUBLIC POLICY
   Southwest Porch
   Edward Jelks, *Chairman*
   Donald W. Smith
   V. Marklin Johnson
   H. Phillip Hampton
   William C. Roberts
3. FINANCE AND ADMINISTRATION
   Men's Card Room
   Duncan T. McEwan, *Chairman*
   Samuel M. Day
   Warren W. Quillian
   Francis H. Langley
   Walter C. Payne Sr.

The Secretary reported the result of the balloting on a delegate to the American Medical Association: Francis T. Holland 63, Thomas H. Bates 58.

Dr. Herpel: "By your vote, you have elected Dr. Holland of Tallahassee as your delegate."

Dr. Bates: "I wish to extend my heartiest congratulations to Dr. Holland."

Dr. George W. Morse: "I would like to nominate Dr. Bates as alternate delegate."

Dr. Alvin L. Mills: "I move that nominations be closed."

Seconded by Dr. Herbert E. White.

Motion carried.

Dr. John D. Milton: "I move that the secretary be instructed to cast a unanimous ballot for Dr. Bates."

Seconded by Dr. Jack Q. Cleveland.

Motion carried.

The Chair announced that resolutions from the floor would be heard at this time.

Dr. Homer L. Pearson Jr. of Dade presented a resolution requesting the Florida Medical Association to appropriate $5,000 to be used for entertaining the members of the House of Delegates, the officers, councils and committee members of the American Medical Association and their wives at the 1954 A.M.A. Clinical Session in Miami.

This resolution was referred to Reference Committee No. 3, Finance and Administration.

Dr. William M. Davis of Pinellas presented a resolution on inviting relief for hospital staff members from attempts of hospital accreditation authorities to impose arbitrary rules and regulations. This was referred to Reference Committee No. 1, Health and Education.

Dr. Rowland E. Wood of Pinellas presented a resolution which was passed by the Pinellas County Medical Society at its regular meeting on February 1, 1954, requesting the American Medical Association to establish a Council on Insurance. This was referred to Reference Committee No. 2, Public Policy.

Dr. H. Phillip Hampton of Hillsborough presented a resolution requesting Blue Shield-Blue Cross to consider offering additional contracts with deductible provisions. This was referred to Reference Committee No. 1, Health and Education.

Dr. Thomas H. Lipscomb of Duval presented a resolution requesting the American Medical Association to reconsider its public relations policies. This was referred to Reference Committee No. 1, Health and Education.

The Chair recognized Dr. Burns A. Dobbins Jr. of Broward.

Dr. Dobbins: "It was the Broward County Medical Association's pleasure to invite the Florida Medical Association to Broward County in 1950, and it was an honor that they chose to return in 1951. In 1952, they were again well received, but in 1953 and 1954, the welcome was beginning to wear a little thin. That is not a unique situation in Florida, as you well know. Many visitors come to the state and many times they do not make plans, so it is necessary to make some for them.

"We, in Broward County, have refused to accept the defeatist attitude of our officers and have conducted a private investigation of our own. I have an invitation from the Development Board of Nassau in the Bahamas, which I would like to read to you. I also would like to present a resolution from the Broward County Delegation, that the Association hold its 1955 annual meeting in Nassau."

This resolution was referred to Reference Committee No. 3, Finance and Administration.

Indian River County Medical Society Resolution — Joint consideration of fee schedule and income limits (Handbook) was referred to Reference Committee No. 1.

Dade County Medical Association Resolution — Definition and regulation of use of word "Clinic" by all members of all branches of the healing arts (Handbook) was referred to Reference Committee No. 1.

Sarasota County Medical Society Resolution — Discontinuation of "Doctor-Draft" law as of its expiration on June 1, 1955 (Handbook) was referred to Reference Committee No. 2.

Sarasota County Medical Society Resolution — Consideration of some city other than Hollywood for the annual meeting (Handbook) was referred to Reference Committee No. 3.

The following committee reports were referred as published in the Handbook:

(To Reference Committee No. 1)

Scientific Work, Jere W. Annis
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Frazier J. Payton*
Venereal Disease Control, Melvin M. Simmons
Tuberculosis and Public Health, Phillip W. Horn
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian
*Supplemental report presented and referred.

(To Reference Committee No. 2)

Conservation of Vision, Sherman B. Forbes
Legislation and Public Policy, H. Phillip Hampton*
Medical Education and Hospitals, Jack Q. Cleveland*
Medical Economics, Reuben B. Chrisman Jr.
State Controlled Medical Institutions, Samuel G. Hibbs
Representatives to Industrial Council, Frank L. Fort
Grievance, Walter C. Payne Sr.
*Supplemental report presented and referred.

(To Reference Committee No. 3)

Board of Governors, Frederick K. Herpel*
Public Relations, Leigh F. Robinson
Necrology, Alvin L. Stebbins*
Advisory to Woman's Auxiliary. C. Robert DeArmas
Councilor Districts and Council, John D. Milton*
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, James V. Freeman
*Supplemental report presented and referred.

Dr. Herpel: "We have received a telegram of greetings from Acting Governor Charley Johns. I have also received a telegram from Mr. C. P. Loranz, regretting his inability to be here to represent the Southern Medical Association. He is retiring and this is his last year as Secretary-Manager of the Southern Medical Association.

"I have another greeting from Dr. B. S. Carroll, Secretary, Florida State Dental Society, extending best wishes for a most successful meeting."

There being no further business, the House of Delegates recessed at 11:15 a.m., to reconvene at 10:30 a.m., Wednesday, April 28, 1954.

Second House of Delegates

The House of Delegates reconvened at 10:35 a.m. on Wednesday, April 28, in the Mardi Gras Room of the Hollywood Beach Hotel, Hollywood, Florida; President Herpel in the Chair.

Dr. Louis M. Orr, Chairman of the Credentials Committee, was recognized and reported that a quorum was present. (Subsequent report of the Credentials Committee showed 118 delegates registered.)

Delegates

ALACHUA—F. Emory Bell, Henry J. Babers Jr.
BAY—William C. Roberts
BREVARD—*(Absent—Gerard E. Christie)*
BROWARD—Fred E. Brammer, Burns A. Dobbins Jr., Donald H. Gahagen, Richard A. Mills, Curtis H. Sory
COLUMBIA—*(Absent—Laurie J. Arnold Jr.)*
DADE—James L. Anderson, Turner E. Cato, Reuben B. Chrisman Jr., Jack Q. Cleveland, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Raymond L. Evans, Richard M. Fleming, James W. Holmes, Ralph W. Jack, Walter C. Jones, Robert P. Keiser, Alfred G. Levin, Donald F. Marion, John D. Milton, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson Jr., Frederick P. Poppe, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., Ralph S. Sappenfield, Donald W. Smith, Franz H. Stewart, Joseph S. Stewart, *(Absent—Ralph F. Allen, R. Spencer Howell, Leonard L. Weil)*
DeSOTO-HARDEE-HIGHLANDS-GLADES—Hubert W. Coleman
DUVAL—Jackson L. Allgood Jr., Frederick H. Bowen, Turner Z. Cason, Karl B. Hanson, Edward Jelks, F. Gordon King, Raymond H. King, Thomas H. Lipscomb, Joseph J. Lowenthal, Wilson T. Sowder, Sidney Stillman, G. Dekle Taylor *(Absent—Hugh A. Carithers)*
ESCAMBIA—Paul F. Baranco, Herbert L. Bryans, Sidney G. Kennedy Jr., George W. Morse, Walter C. Payne Sr.
FRANKLIN-GULF—Albert L. Ward
HILLSBOROUGH—C. Frank Chunn, Herschel G. Cole, Joshua C. Dickinson, H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., William M. Rowlett, J. Maxwell Williams Jr. *(Absent—Leffie M. Carlton Jr.)*
INDIAN RIVER—John P. Gifford
JACKSON-CALHOUN—Grayson C. Snyder
LAKE—C. McK. Tyre
LEE-CHARLOTTE-COLLIER-HENDRY—William H Grace, Baker Whisnant
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Julius C. Davis, Francis T. Holland *(Absent—T. Bert Fletcher Jr.)*
MADISON—Harry A. Nevel
MANATEE—*(Absent—Millard P. Quillian)*
MARION—Eugene G. Peek Jr.
MONROE—Ralph Herz
NASSAU—Cecil B. Brewton
ORANGE—Frank C. Bone, David Y. Hicks Jr., Edgar E. Hitchcock, Walter B. Johnston, Carl S. McLemore, Louis M. Orr, Adelbert F. Schirmer, Charles R. Sias
PALM BEACH—Thomas E. Daly, C. Jennings Derrick, V. Marklin Johnson, Graham W. King Jr., Ralph M. Overstreet Jr., Cecil M. Peek
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—William M. Davis, N. Worth Gable, Francis H. Langley, Norval M. Marr, James H. Miller Jr., Alvin L. Mills, Richard Reeser Jr., John P. Rowell, Rowland E. Wood
POLK—Jere W. Annis, Samuel J. Clark, Ivan W. Gessler, Marion W. Hester
PUTNAM—Lawrence G. Hebel
ST. JOHNS—Herbert E. White
ST. LUCIE-OKEECHOBEE-MARTIN—John T. McDermid
SARASOTA—John M. Butcher, Melvin M. Simmons
SEMINOLE—*(Absent—John M. Morgan)*
SUWANNEE—Edward G. Haskell Jr.
TAYLOR—*(Absent—Ralph J. Greene)*
VOLUSIA—C. Robert DeArmas, Peter A. Drohomer, Herbert A. King *(Absent—Joseph H. Rutter)*
WALTON-OKALOOSA—*(Absent—Arthur G. Williams Sr.)*
WASHINGTON-HOLMES—*(Absent—Martin L. Lane)*
STATE OFFICERS—Frederick K. Herpel, Duncan T. McEwan, Thomas H. Bates, Russell B. Carson, Thomas C. Kenaston, Samuel M. Day, Shaler Richardson

Report of Reference Committee No. 1

The Chair called for the report of Dr. John D. Milton, Chairman of Reference Committee No. 1, Health and Education. This commimttee was composed of Drs. Jere W. Annis, G. Dekle Taylor, C. Frank Chunn, Francis T. Holland and the chairman.

Dr. Milton: "The Committee on Health and Education had quite a long session and took the following actions.

"The report of the Committee on Scientific Work as presented by Dr. Jere W. Annis, Chairman, is approved as published in the Handbook and I move its adoption."

Seconded by Dr. Homer L. Pearson Jr.

Motion carried.

Report of Committee on Scientific Work

Jere W. Annis, *Chairman*

The Scientific Work Committee has endeavored to uphold the high level of programs established by the previous committee. It feels gratified that the members of our Association have responded so whole-heartedly to our request for scientific contributions.

We of the Committee are delighted that forty excellent papers were submitted and we are chagrined at the necessity of having the responsibility of selecting only eighteen from this number. Diversification and composition of the program were the greatest determining factors in this selection. It is our conviction that the submission of this many papers of exceptional quality — not all from physicians within the state — denotes the "coming of age" scientifically of our Association and of our program as representative of it. It establishes these sessions as valued and esteemed scientific outlets with a dignity of their own. We have again arranged a short symposium — this time on jaundice — which we hope meets with your approval.

The Committee met in Orlando on Nov. 22, 1953, and following the completion of the program voted to recommend to the House of Delegates that in the future, this Committee be allowed upon application a sum of money not to exceed $250 to be used to defray traveling expenses only of any out-of-state speaker that might be desired as moderator for a symposium. This sum would not necessarily be utilized annually but only in the event a symposium was to be held and only in the event that a suitable speaker could not be obtained gratis or through some specialty organization who would defray his expenses. The lack of such funds has been a handicap to the Committee in attempting to arrange the best possible program in the past.

Finally, we wish to thank our noted visitors from out of the state, our very able speakers from our own Association, and our sincere and cooperative friends whose excellent papers because of time could not be included in the program. To all of these physicians goes credit for the quality of the Scientific Program.

Respectfully submitted,
Jere W. Annis, *Chairman*

Dr. Milton: "The report of the Committee on Medical Postgraduate Course as presented by Dr. Turner Z. Cason, Chairman, is approved as published in the Handbook and I move its adoption."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Twenty-First Annual Graduate Short Course for doctors of medicine was held in Jacksonville, June 22-27, 1953 with a total attendance of 165. Of this number 15, or 9 per cent, were Negro physicians who registered under the Agricultural and Mechanical University at Tallahassee.

Prior to the Short Course a special course in Gastroenterology was held in Jacksonville, June 18-20, with 47 in attendance.

In 1952-1953 the Florida Clinical Diabetes Association was organized. The Association held its first annual meeting in St. Petersburg on May 14-15, 1953 in conjunction with the fifth annual Diabetes Seminar which was sponsored by the Association and other agencies. The Medical Postgraduate Course Committee had previously approved this procedure. Total registration for this course was 53.

The Eighth Annual Midwinter Seminar in Ophthalmology and Otolaryngology was held in Miami Beach, January 18-23, 1954 with 225 physicians in attendance.

A Seminar on Medicine and Surgery was presented in Gainesville by the Faculty of the Department of Medicine of the Graduate School of the University of Florida on January 27, 1954, with 44 physicians attending.

These courses were outlined and approved by the Medical Postgraduate Course Committee and preparations were made by the Department of Medicine of the Graduate School of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health.

The Committee met at the George Washington Hotel in Jacksonville on June 24 and November 1, 1953 and on February 7, 1954. In addition to the Committee members, Dr. Lorenzo L. Parks attended, representing the Florida State Board of Health.

The Committee has continued its efforts to find a way by which expenses incurred by physicians attending graduate medical education courses in Florida could be deducted for income tax purposes. The information from California, as noted in the 1953 report, was not fruitful. We are still advised that the American Medical Association is making continued efforts to have graduate medical education expenses a deductible item in computing income tax.

Due to the meeting of the American Medical Association late in June in San Francisco, the Committee considered it best to hold the Twenty-Second Annual Graduate Short Course in July of 1954, the dates set being July 12-16. The meeting of the American Medical Association this June comes at the same time the Short Course has been held since its beginning 22 years ago.

The question of continuing the lectures of the Short Course through Saturday was discussed again this year by the Committee. Since, upon review, the attendance at previous meetings did not seem to justify continuation of these Saturday morning lectures, the course to be held July 12-16, 1954 will be for five days only instead of the usual five and a half days. Obstetric lectures will also be omitted from the course this year. The Committee noted that the attendance for these lectures was not large, and thought that the Tri-State Obstetric Seminar held in Daytona Beach the past few years was supplying well this phase of graduate education.

The Committee approved the continued cooperation with the Florida Clinical Diabetes Association. The Diabetes Seminar will be held in Orlando on October 21-22, 1954 at the time of the second annual meeting of this association.

It was recommended and approved by the Committee that all retired physicians attending the graduate medical education courses not be required to pay registration fees.

The Committee approved continuation of the one day graduate courses to be presented upon request by the Faculty of the Department of Medicine of the University. The course presented in January 1954 in Gainesville was co-sponsored by the Alachua County Medical Society and the Marion County Medical Society. Plans for additional courses are under way.

At the request of the Director of the Department of Medicine, the Committee has submitted recommendations for revision of the Faculty of the Department of Medicine. These recommendations will be forwarded to the Dean of the Graduate School, who in turn will submit them to the President of the University of Florida and the Board of Control for approval.

In addition to the activities noted, the Committee has reviewed suggestions for new teachers in all fields of graduate medical education and for various types of courses to be presented, and has formulated plans for the forthcoming year's work.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Milton: "The report of the Committee on Cancer Control as presented by Dr. Frazier J. Payton, Chairman, is approved with the addition of the supplemental report which is to take the place of the final paragraph as printed in the Handbook. I move that this report be adopted."

Seconded by Dr. Homer L. Pearson Jr.

Motion carried.

Report of Committee on Cancer Control

Frazier J. Payton, *Chairman*

The activities of this Committee have been almost entirely those of the activities of the Florida Cancer Council with its duly appointed representatives from this Committee. The outstanding problem facing the activities of this Committee has been:

A sharp cut in federal funds for cancer control and the cut in state funds by our last Legislature. This has grossly hampered the Committee activities in the state, but fortunately through the activities of the Florida Cancer Council and interested and influential friends of cancer control, approximately $52,000 was restored from state funds, under the control of the governor of the state of Florida and his cabinet.

Several tumor clinics have been investigated and approved.

Supplement

The Committee, through its representatives on the Florida Cancer Council, has recommended that those phases of the Cancer program not taken care of by state and or federal agencies be returned to a county basis with special reference to terminal care and the expense of hospitalization, if necessary, in other counties so that all would more equitably bear the burden to the greater benefit of those needing it.

Respectfully submitted,
Frazier J. Payton, *Chairman*

Dr. Milton: "The report of the Committee on Venereal Disease Control presented by Dr. Melvin M. Simmons, Chairman, is approved as published in the Handbook. I move the report be adopted."

Seconded by Dr. Shaler Richardson.

Motion carried.

Report of Committee on Venereal Disease Control

Melvin M. Simmons, *Chairman*

Advances can be reported in the control of venereal disease in Florida during the year 1953. Most of these are a result of the effectiveness of our old friend penicillin.

Using syphilis as a barometer, the number of reported cases remains about the same as the year 1952. However, there continues to be an increasing preponderance of latent cases as compared to primary infectious cases. This is interpreted as an indication of decrease in incidence to be reflected in future statistics.

Again the reported cases are divided equally between private physicians and the Florida State Board of Health. The facilities for contact follow-up available at the Board of Health are being made known by personal letter to each reporting physician, and are being used increasingly. The cooperation expected from this personal liaison between reporting physician and the Board of Health is expected to produce increasing results in case finding.

It is pleasing to report that your State Board of Health by effecting economies in treatment methods, has been enabled to continue the entire venereal disease program without loss of effectiveness in spite of considerably less in federal funds.

For the forthcoming year, your Committee recommends continuation of the present cooperation betweeen private physician and the Board of Health in reporting of cases and adequate contact follow-up.

Respectfully submitted,
Melvin M. Simmons, *Chairman*

Dr. Milton: "The report of the Committee on Tuberculosis and Public Health presented by Dr. Phillip W. Horn, Chairman, is approved as published and I move its adoption."

Seconded by Dr. Edward W. Cullipher.

Motion carried.

Report of Committee on Tuberculosis and Public Health

Phillip W. Horn, *Chairman*

Your Committee on Tuberculosis and Public Health had no major problems presented for action during this year which necessitated a call for a formal meeting of the entire Committee. The following matters were handled by correspondence:

Letters were written to the senators and representatives during the past session of the legislature recommending that the Tuberculosis Board be increased to five (5) members, each serving different terms. The enlargement of the Board was approved. This important Board which controls the tuberculosis sanatoriums of the state is at the discretion of business men and interested lay individuals. It is felt that, at the appointment of the next member, recommendations should be submitted to the governor to the effect that one doctor should be appointed to this Board.

A criticism of the extent of the state and county Public Health Service into the various fields of medicine, especially the immunization of school children in Sarasota, was received. It was felt that this was a matter for the local medical society to discuss with the local health officer and be settled amicably by them.

In January 1954, the Chairman of your Committee attended the meeting on Rural Health held in Birmingham, with Dr. Charles Henry from the American Medical Association leading the discussion. The problems of health and sanitation in the sparsely settled areas of our state were discussed in relation to the available hospitals, distribution of physicians, hospital insurance, and indigent care. These were considered in the recommendations as to improvement in the medical care that might be made.

Florida has made considerable progress in the smaller communities in all these fields with the exception of the distribution of physicians. It might be well for the Florida Medical Association to keep an accurate chart pertaining to this distribution of physicians in the state with presentation of this fact to the State Board of Medical Examiners each time they meet in order to encourage the younger doctors to settle in these communities which definitely are in need of additional medical care.

The problem of tuberculosis, as far as mortalities are concerned, is decreasing; however, the diagnosis of early tuberculosis is one of the major factors in the control of this disease. The Florida State Board of Health, Bureau of Tuberculosis, continues to accomplish excellent results in the detection of early cases. It is recommended by your Committee that the Florida Medical Association go on record as endorsing the function of this department of the State Board of Health and encouraging physicians in this department to follow up the patients who seek further examination and care following a report by the x-ray service that their x-ray was suspicious of tuberculosis or other pathology.

Respectfully submitted,
Phillip W. Horn, *Chairman*

Dr. Milton: "The report of the Committee on Maternal Welfare as presented by Dr. E. Frank McCall, Chairman, and published in the Handbook is approved and I move its adoption."

Seconded by Dr. Frederick H. Bowen.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

We have formed no new Maternal Welfare Committees in the state this year, but those already formed are doing a very excellent job of reviewing the maternal deaths in their communities.

The Maternal Welfare Committee sponsored by the State Boards of Health of Georgia, Florida, and South

Carolina, held an Obstetric and Pediatric Seminar at Daytona Beach, September 14-16. This meeting was better attended than any of the previous years. Total registration was 253. The faculty for this meeting was as follows:

Dr. Charles A. Poindexter, New York University; Dr. M. Edward Davis, University of Chicago; Dr. Alton Ochsner, Tulane University; Dr. C. R. Stephen, Duke University; Dr. Fred L. Adair, Maitland, Fla; Dr. Allan C. Barnes, Western Reserve University, Cleveland, O.; Dr. Carl P. Huber, Indiana University; Dr. Edith L. Potter, University of Chicago; Dr. Robert B. Lawson, Wake Forest College; Dr. Hugh A. Carithers, Jacksonville, Fla.

For this meeting we were able to obtain eight exhibitors which helped to defray the cost of the meeting. The rest was provided for by the Florida State Board of Health (Bureau of Maternal and Child Health).

Plans have been completed to continue this meeting in Daytona Beach in September and a representative group of outstanding professors have been obtained for this meeting. Enough exhibitors have been obtained for the 1954 meeting to make it almost a self-sustaining program.

It is with pleasure that we report only sixty-five maternal deaths in Florida for the year 1953. This gives us a maternal mortality of 0.8 per 1,000 for the state, which is the exact figure for 1952. The 1952 figure was a reduction of 33 per cent over any previous year. This reduction placed Florida well among the top states in the nation. Since this was such a tremendous reduction, we are delighted to have been able to maintain this figure for 1953. Again Florida will rank among the top states in the nation in regard to maternal mortality, and we would like to give due credit to the many Florida physicians who have helped us maintain this level.

Respectfully submitted,
E. Frank McCall, *Chairman*

Dr. Milton: "The report of the Committee on Child Health as presented by Dr. Warren W. Quillian, Chairman, and published in the Handbook is approved and I move its adoption."

Seconded by Dr. Thomas H. Lipscomb.

Motion carried.

Report of Committee on Child Health

Warren W. Quillian, *Chairman*

Activities of the Committee on Child Health during the past year have been handled largely through correspondence. Some progress has been made through coordinated effort with the Florida Chapter of the American Academy of Pediatrics and with the Florida Pediatric Society. Existing committees from these groups have a planned program concerning accident prevention in childhood and a study of problems pertaining to the fetus and newborn. Personnel supervising the study include members of the Committee on Child Health.

Public interest in the improvement of child health is rapidly growing. To the physician, it seems a reasonable assumption that better medical care for more children involves a modification of existing programs of medical education and the improvement of facilities for child care. Many rural areas in our state are handicapped by a lack of clinic, specialists and hospital care and do not have highly skilled diagnostic or treatment services. It is desirable that the individual physician serving these areas be well qualified in the management of problems pertaining to child health. Your Committee recommends that the Legislative Committee of the Florida Medical Association study means of modifying the present Medical Practice Act in order that a section may be given on the state medical board examination on Pediatrics. Authoritative studies indicate that fully one-third of the practice of those physicians engaged in the general practice of medicine consists of pediatric problems.

A request has been received from the Florida State Board of Health for an opinion from the Committee on Child Health concerning approval of prophylactic materials other than silver nitrate for the eyes of newborn infants. There is no complete unanimity of opinion. The consensus of the Committee is that the use of silver nitrate should not be mandatory, but may be replaced by a suitable antibiotic solution or ointment.

Dr. Turner E. Cato, director of the Dade County Public Health Department, represented your Committee at a National Conference on Physicians and Schools at Highland Park, Ill., Sept. 30 to Oct. 2, 1953. There was a general discussion of participation of the physician in school health services and a suggested program of school health policies, as well as the health appraisal of school children. It is planned to have the physicians of the Florida Medical Association cooperate actively in this program, which is recommended by the A.M.A. Bureau of Health Education.

Care for the children of indigents and local child welfare problems must be met and managed in the individual communities. Your Child Health Committee is willing to help and often does assist in the solution of these problems. These activities are unofficial and are sponsored by the individual physicians since there are few funds available for a state-wide organized effort.

Respectfully submitted,
Warren W. Quillian, *Chairman*

Dr. Milton: "The resolution by the Indian River County Medical Society on joint consideration of fee schedules and income limits is approved with the following recommendation: That it be presented to the Medical Economics Committee for study and recommended to Blue Shield provided it is actuarially sound. I move its adoption as amended."

Seconded by Dr. C. Frank Chunn

Motion carried.

Resolution

Whereas, the insurance commission has recommended an increase in the income limits of Blue Shield subscribers in this state, the Indian River County Medical Society desires to go on record as follows:

We feel that in revision of the schedule, the fee schedule and income limits should be considered jointly.

We feel that many fees in the schedule are too ow for the proposed income limits.

Respectfully submitted,
Vernon L. Fromang, *Secretary*
Indian River County Medical Society

Recommendation

The Reference Committee recommends that this resolution be presented to the Medical Economics Committee for study and recommended to Blue Shield provided it is actuarially sound.

Dr. Milton: "The resolution by the Dade County Medical Association on definition and regulation of use of the word 'Clinic' by all branches of the healing arts was approved and referred to the Board of Governors for proper action, with certain changes in the text of the findings of the Dade County Medical Association committee (Report of the 'Clinic' Committee of the Dade County Medical Association). The changes are as follows:

"Item 2, section (a) be changed to read: That a 'Clinic' be defined as a group of three or more regular Florida licensed physicians.

"Item 2, section (c) be changed to read: That

such terms as Medical Center, Group, Associates, Diagnostic Center, or any other word or group of words that imply two or more licensed physicians to be involved shall be considered synonymous with the term 'Clinic.'

"Item 2, section (e) be changed to read: That every such clinic conducted by doctors of medicine must apply to the county medical society for approval of its clinic name and thus register its name and membership with the county medical society. Changes in its membership must also be recorded with the county medical society.

"Item 2, section (f) be changed to read: That all groups of doctors of medicine practicing under a clinic or synonymous term name at the time this change is made in the By-Laws be allowed a period of two years from such date either to conform to these ethical regulations or to drop the clinic name and take down all signs designating it as such.

"Item 4, be reworded to clarify the fact that we do not approve these groups (other healing art groups).

"I move that this resolution as amended be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution

It is recommended that the DCMA approve recommendations of the special Clinic Committee of 1952 as contained in its report of July 1952, a copy of which is attached hereto, regarding the definition and use of the word "Clinic" and synonymous terms, and recommends to the FMA that it endorse, by resolution, the action of the DCMA in this matter and recommend to its county medical societies that it should take steps by resolution to adopt the regulations on the use of the word "Clinic" as propounded by the DCMA; and that after such adoption, that the FMA and its component medical societies formulate a bill for introduction into the Florida Legislature convening in 1955 to define and regulate the use of the word "Clinic" by all members of all branches of the healing arts.

Respectfully submitted,
Kenneth S. Whitmer, *Secretary*
Dade County Medical Association

Report of the "Clinic" Committee of the Dade County Medical Association

During June 1952 the Committee corresponded with the American Medical Association, The American College of Physicians, The American College of Surgeons, and the American Association of Medical Clinics in an effort to obtain some officially accepted definition of the word "Clinic."

The Committee met at 5 p.m. on July 2, 1952, in the office of the Chairman, Ralph W. Jack, M.D. All members were present with the exception of Benjamin G. Oren, M.D. The correspondence received from the above-named organizations was reviewed, and definitions of "Clinic" in Funk and Wagnalls, Century, Webster's Standard, and Dorland Medical dictionaries were studied. The general problem created by the misuse of this and synonymous words or phrases by the medical profession and other healing art groups, and the best approach to the correction of such, was thoroughly discussed.

The Committee came to the following conclusions and presents them as recommendations to the Executive Committee for their consideration.

(1) That the Legislative Committee present a resolution to the Dade County Medical Association so as to make the necessary changes in the By-Laws in the way that the committee deems best to accomplish the desired regulations. One of two things apparently will have to be done. Either change the present By-Laws to include these regulations, or add these new regulations to the Dade County Medical Association code of ethics and then change the By-Laws so as to adopt the Dade County Medical Association code of ethics in addition to the American Medical Association code of ethics. Apparently, when the Constitution and By-Laws were changed in 1948, the Dade County Medical Association code of ethics was dropped. It is the opinion of this Committee that there should be a local code of ethics as well as following that of the American Medical Association which could include such regulations as the present subject.

(2) That this resolution include the following:
  (a) That a "Clinic" be defined as a group of three or more regular Florida licensed physicians.
  (b) If a clinic offers a specialty service, the name of the specialty must be included in the clinic name.
  (c) That such terms as Medical Center, Group, Associates, Diagnostic Center, or any other word or group of words that imply two or more licensed physicians to be involved shall be considered synonymous with the term "Clinic."
  (d) That no member of the Dade County Medical Association shall practice in, or be associated with, any "Clinic" that does not conform to this definition.
  (e) That every such clinic conducted by doctors of medicine must apply to the county medical society for approval of its clinic name and thus register its name and membership with the county medical society. Changes in its membership must also be recorded with the county medical society.
  (f) That all groups of doctors of medicine practicing under a clinic or synonymous term name at the time this change is made in the By-Laws be allowed a period of two years from such date either to conform to these ethical regulations or to drop the clinic name and take down all signs designating it as such.
  (g) That it shall become the duty of the Membership Committee to instruct each new Provisional Member of these regulations.

(3) That as soon as such resolution is adopted by the Dade County Medical Association, a copy of such be sent by the secretary to all other county societies in the Florida Medical Association urging them to adopt similar regulations.

*(4) That a copy be sent to the Board of Governors and the Legislative Committee of the Florida Medical Association informing them of our action and requesting them to consider similar action on a state level, and particularly to consider the best and quickest means to get state legislation on this problem so as to include the other healing art groups as well as the medical profession, as a public health measure.

(5) That a copy be sent to the Editor of The Journal of the Florida Medical Association for publication requesting that there be an editorial urging the other county societies to take similar action.

Respectfully submitted,
Ralph W. Jack, M.D., *Chairman*

*To be reworded by the Board of Governors to clarify the fact that the Association does not approve other healing art groups.

Dr. Milton: "The resolution from the Hillsborough County Medical Association Delegation, requesting Blue Shield-Blue Cross to consider offering additional contracts with deductible provisions, is approved with the recommendation that it be forwarded to Blue Shield for study. I move that this be approved."

Seconded by Dr. C. Frank Chunn.

Motion carried.

Resolution

WHEREAS: Voluntary health insurance is the most feasible method of providing for the cost of major illness, injury or surgical procedure. A plan which will insure payment of that cost must be protected from abuse and cannot become bogged down in minor claims which will not satisfy the need but will greatly increase the premiums necessary to support it.

The intent of Blue Shield and Blue Cross medical and hospital insurance and its place in our economy is based on the principle of providing for the financial impact of serious illness, injury or surgical procedure by moderate monthly payments which may be budgeted in anticipation of the need.

Failure of such plans may occur through lack of public acceptance or bankruptcy caused by abuses in unnecessary hospitalization for minor illnesses, surgery or diagnostic purposes.

Clerical processing of many minor claims increases the operating costs, thereby lowering benefits and increasing premiums. The payment of minor claims is not in keeping with the purpose or necessity for Blue Cross and Blue Shield insurance.

A deductible Blue Shield policy and a deductible Blue Cross policy (with perhaps certain exceptions, such as maternity), expecting payment of the first several dollars in medical and surgical fees and the first several dollars of hospital cost by the insured, would permit an appreciable decrease in premium, more extensive coverage to the insured and discourage insurance abuses. (The exact deductible amount to be determined actuarially.)

THEREFORE, BE IT RESOLVED that the Florida Medical Association recommends *additional* Blue Shield and Blue Cross contracts to be actuarially prepared on the basis of the first several dollars of hospital expense and the first several dollars of physicians' and surgeons' fees to be paid by the insured, and offered to the people of Florida at a lower premium, with more extensive coverage and permit the insured a free choice of the policy he prefers.

Respectfully submitted,
The following Delegates of the
Hillsborough County Medical Association:

David R. Murphey Jr.
C. Frank Chunn
H. Phillip Hampton
William M. Rowlett
Herschel G. Cole
Leffie M. Carlton Jr.
J. Maxwell Williams Jr.
Eugene B. Maxwell
Joshua C. Dickinson

Recommendation

The Reference Committee recommends that this resolution be forwarded to Blue Shield for study.

Dr. Milton: "The resolution of the Pinellas County Medical Society on inviting relief for hospital staff members from attempts of hospital accreditation authorities to impose arbitrary rules and regulations, is approved with the following amendment: That all paragraphs with the exception of 10 and 12 be entirely deleted and that in paragraph 12, line 2, the word 'hospital' be inserted before the words 'certifying commission.' I move that this resolution be adopted as amended."

Seconded by Dr. F. Gordon King.

Motion carried.

Resolution

Be It Resolved that this Society go on record as demanding a halt to the attempts by hospital accreditation authorities to propose, recommend and by threat of reprisal force the adoption of rules, regulations and various and divers requirements which would look to the most minute and detailed overlordship in every phase of our hospital practices.

Be It Finally Resolved, that the American Medical Association, as a party to the hospital certifying commission, look actively to the defense of the members of the American Medical Association, in order that they do not become the recipients of a most obnoxious and unnecessary burden.

Respectfully submitted,
W. C. McConnell, *Secretary*
Pinellas County Medical Society

Dr. Milton: "Gentlemen, I will assure you that the next resolution — the resolution from the Duval County Medical Society requesting the American Medical Association to reconsider its public relations policies — received a great deal of discussion, some of which was a little heated. After hearing both sides on this resolution, the committee went into executive session and had some additional discussion. We finally reached the conclusion that this resolution be disapproved with the following comment:

1. Your Reference Committee recognizes the fact that the resolution as presented develops several points of importance to the members of this Association.
2. Certain component societies of this Association and their members are to be reprimanded for their laissez-faire attitude in matters of public relations and should realize that such public relations are their initial responsibility and should be carried out in a positive manner with the assistance of the public relations departments of the Florida Medical Association and the American Medical Association.
3. That practically, the points of this resolution have already had their effect nationally and the American Medical Association is cognizant of this Association's feeling in the matter.
4. Your Reference Committee believes that the Public Relations Department of the

American Medical Association should vigorously publicize in no defensive or apologetic manner, the good of organized medicine and unselfish devotion to their work by physicians as a whole, which has given Americans the finest medical care in the world.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. C. Frank Chunn.

Dr. Jelks: "You said that the report not be published. Are you not going to publish the remarks in The Journal?"

Dr. Milton: "Just the resolution will not be published. The comments will be published."

Dr. Herpel: "The purpose, as I understand it, is to have all these remarks which Dr. Milton has made in explaining the disapproval of the resolution published in The Journal. I can assure you that there has been no attempt on the part of anyone to beat down these resolutions and there has been every attempt to let everyone be heard and give justice to all points of view. It is the recommendation that the resolution be not approved, and not published, but that the comments be published."

Motion carried.

Report of Reference Committee No. 2

The Chair called for the report of Reference Committee No. 2, Public Policy, by Dr. Edward Jelks, Chairman.

Dr. Jelks: "Reference Committee No. 2 had a meeting yesterday afternoon with not quite as much argument as the one you just heard. All members were present, Drs. Donald W. Smith, V. Marklin Johnson, H. Phillip Hampton, William C. Roberts and your chairman, and these recommendations are the unanimous opinion of the committee. We will reverse the order and take up the resolutions first.

"The resolution on discontinuation of the "Doctor-Draft" law as of its expiration on June 1, 1955, presented by the Sarasota County Medical Society is approved as published in the Handbook, and I move that it be adopted."

Seconded by Dr. John D. Milton.

Motion carried.

Resolution

WHEREAS, there no longer exists any military emergency; and

WHEREAS, the Doctor Draft law as it exists is discrimnatory legislation; and

WHEREAS, the Armed Services have not exhausted all possible measures of attracting medical personnel by making a service career attractive;

BE IT RESOLVED that the Sarasota County Medical Society request that the Doctor Draft law be discontinued as of its expiration on June 1, 1955.

Respectfully submitted,
Lloyd J. Duest, *Secretary*
Sarasota County Medical Society

Dr. Jelks: "The resolution by the Pinellas County Medical Society, requesting the American Medical Association to establish a Council on Insurance, presented by Dr. Rowland E. Wood, is approved and I move that it be adopted."

Seconded by Dr. Ralph Herz.

The Chair recognized Dr. Louis M. Orr of Orange.

Dr. Orr: "Because of my attendance at the meeting of Reference Committee No. 1, I was unable to be present at the time this resolution was discussed. As you will notice in the lobby, in the exhibit of the Council on Medical Service, one of the principal committees of this Council is the Committee on Prepayment Medical and Hospital Service. This committee has been functioning for a number of years. Please, if you act favorably on this resolution, let it stay in Florida. We cannot take it to the A.M.A. as they already have a committee on this subject."

The Chair recognized Dr. Rowland E. Wood.

Dr. Wood: "When this resolution was written, we were aware of the fact that there was a committee on insurance of the A.M.A.; however, we did not feel that the committee was doing what we would like for it to do. The purpose of this resolution is to call to the attention of the A.M.A. and its committee on insurance certain things that we think should be done. We don't know whether it could be best handled by a committee, a council, or a commission; it is for the A.M.A. to decide the best way to handle it, but what we want done is for the A.M.A. to study the various types of prepayment illness insurance and professional service policies and set up standards for those policies, so they can put their seal of approval on policies which meet those standards. We, as physicians, have no way of knowing just what our patients' insurance policies will do. Councils of the A.M.A. in the past have set up standards for foods, drugs, hospitals, physical

therapy equipment, etc., and have awarded the seal of approval to those products which met the standards. They also regulate the advertising on such products. The advertising must meet A.M.A. standards and that is what we are driving at. We are not familiar with the mechanism of the A.M.A. but we want to call these things to their attention and hope that they will do something about it."

The Chair recognized Dr. Franklin J. Evans of Dade.

Dr. Evans: "I think the resolution, as it is printed is very noteworthy, but as I read it over, I was impressed with the fact that not only is this a stupendous job, but one that could not be accomplished.

"You are familiar with the fact that there are thousands of companies writing thousands of different types of policies, and for the A.M.A. to attempt to go through each one and try to standardize it would be an impossible task. Every state has an Insurance Commissioner and Department of Insurance, and we would be encroaching on the authority of the state insurance commissioners, and probably not to our benefit. As it is, there is criticism against organized medicine as such, for encroaching on certain things which it should not. Things like food and medicine come within our purview; those are things we handle, but on a subject like insurance, which we are not selling, but which is being sold to patients and to non-medical people — for the A.M.A. to try to dictate a thing like that would reflect upon organized medicine, as such, trying to review and regulate the writing of insurance. That is a tremendously big field and too great for any society or the A.M.A. to cover.

"I think Pinellas County had a very good purpose in mind, and I am also mindful of insurance abuses, but I think we are getting out of our field if we vote for a Council of this type."

Dr. Orr: "I can see now what Dr. Wood is talking about. I would like to offer the following amendment. I move that this matter be referred to the Board of Governors for study and report at the next annual meeting."

Seconded by Dr. Turner Z. Cason.

Amendment carried.

Original motion as amended upon being put to vote duly carried.

Resolution

WHEREAS, for a number of years, the American Medical Association, as part of their announced program, has urged the public to participate in prepaid insurance programs to aid in the payment of hospitalization and/or the payment of physician fees, and

WHEREAS, the American Medical Association has for many years established Councils for the standardization of drugs, medical equipment, hospitals, etc., and

WHEREAS, many practicing physicians believe that the prepaid insurance program is or will be jeopardized by the lack of uniformity of the insurance policies written by the various companies, by the claims made in some of the published advertisements of these policies, by the false impressions given by some agents selling the policies, and by the failure of the public to read and/or understand the policy they buy,

BE IT RESOLVED, that the Pinellas County Medical Society, Inc., respectfully request that the American Medical Association create a Council on Insurance to study this problem, to establish standards which are fair to the public and the inusrance companies alike, and to set the seal of their approval on all policies meeting those standards, so that the practicing physician may be intelligently advised in these matters, and

RE IT FURTHER RESOLVED, that a copy of this resolution be sent to the American Medical Association, state medical associations, county or unit medical societies, and delegates to the next Convention of the American Medical Association promptly.

Respectfully submitted,
W. C. McConnell, *Secretary*
Pinellas County Medical Society

Amendment

The Reference Committee recommends that this resolution be referred to the Board of Governors for study and report at the next annual meeting.

Dr. Jelks: "The report of the Committee on Conservation of Vision presented by Dr. Sherman B. Forbes, chairman, is approved and I move its adoption."

Seconded by Dr. Shaler Richardson.

Motion carried.

Report of Committee on Conservation of Vision

Sherman B. Forbes, *Chairman*

1. It is the feeling of the Committee on Conservation of Vision that there should be a closer supervision of visual screening of school children. Undoubtedly, there is a definite need for a complete review by a committee composed of ophthalmologists of the tools being used in the screening process. There is also a need of greater interest and participation by ophthalmologists in this activity.

2. There should be a concerted effort by a group composed of pediatricians, obstetricians and public health personnel together with ophthalmologists to assist in the vital problem of retrolental fibroplasia. The committee should be prepared to submit information on the subject for the use of hospitals, pediatricians, ophthalmologists, health and other agencies for the purpose of cooperating in early detection, treatment and care of potential retrolental fibroplasia cases. There is also a need for information to help and prepare parents in accepting the child's visual loss.

3. It is the Committee's opinion that there is a need for a review as a continuous project by ophthalmologists of a practical means of screening adults in industry by ophthalmologists for the detection of glaucoma. Possibly the practice of routine tonometry tests of all persons over 40 might be found to be the most successful method of discovering a large number of glaucoma cases. Certainly, a committee of ophthalmologists should be formed in the state to work out a practical method of mass screening for glaucoma. This committee might possibly work with physicians engaged largely in industrial work in a mass screening of this type.

4. It is the feeling of this Committee that all future Conservation of Vision or similar committees should work in close conjunction with the Florida Council for the Blind who have accrued a wealth of practical material in the state on sight conservation and allied subjects.

Respectfully submitted,
Sherman B. Forbes, *Chairman*

Dr. Jelks: "On the report of the Committee on Legislation and Public Policy by Dr. H. Phillip Hampton, Chairman, that portion which was printed in the Handbook is approved. On the supplement to the report, the Reference Committee recommends that the last paragraph be changed to read: 'Therefore, it is recommended, that the Florida Medical Association through its Board of Governors, at its discretion, request the Governor of Florida to appoint a commission to study the problem of hospitalization of the indigent in Florida and make recommendations for a legislative act to provide hospitalization for the indigent.'

"I move that the report in the Handbook and the supplement as amended be approved."

Seconded by Dr. Wilson T. Sowder.

The Chair recognized Dr. Franklin J. Evans.

Dr. Evans: "I would like to ask Dr. Hampton a question. He recommends that the pre-legislative meeting be held approximately one year befor the Legislature meets. What would happen if something were to arise in the intervening year?"

Dr. Hampton: "I think such an emergency matter would be handled by the committee in conference with the Board of Governors."

Dr. Herpel: "I sat in on some of the discussions and talked to Dr. Hampton and, as I understand it, the purpose was to have a meeting approximately a year before the Legislature begins so that we can set up some type of legislative program. In the interval, the committee and the Board of Governors would function or a special meeting could be called if necessary."

The Chair recognized Dr. Fred E. Brammer of Broward.

Dr. Brammer: "What about the next Legislature? Doesn't it meet next year?"

Dr. Herpel: "You are directing the incoming president to take such action as indicated under the By-Law change."

Motion carried.

Report of Committee on Legislation and Public Policy

H. Phillip Hampton, *Chairman*

The chief activities of your Committee were in connection with the 1953 Session of the Florida State Legislature.

Your Committee studied all the proposed legislation received from county medical societies, referred by the Association's president and requested by the House of Delegates. This proposed legislation was discussed at a pre-legislative joint conference and a definite program was adopted. This program was sent to the chairman of the legislative committee and a copy to the president and secretary of each county medical society urging them to inform their membership and also to explain the proposed legislation to the Representatives of their county and Senator of their district prior to the 1953 Session.

An office was maintained at Tallahassee during the entire session of the Legislature by the Association's Bureau of Public Relations Supervisor and an attorney. This office was for the convenience of legislators and others seeking information on problems concerning medicine and health as they effect legislation for the protection of Florida citizens.

All legislation sponsored by our Association was killed by the Senate Public Health Committee during the session.

Considerable time and labor were devoted to "watch dog" activities. All bills introduced were carefully checked by title and those with any remote possibility of containing sections whicb would be deleterious to public health were studied thoroughly. Tbis proved advantageous for we were instrumental in having several bills amended before becoming laws and in having other bills killed.

It is most apparent that the success or failure of our Association's state legislative program depends primarily upon work done at the local level by having an informed membership and developing better relations witb the legislators at home prior to the legislative session.

Your Committee plans to carry on the activities as in previous years and also to emphasize the coordination of county medical societies and allied professional groups in tbe legislative program. This is to include a series of district meetings with the county medical society legislation committees and officers at least six months prior to the legislative session to explain the objectives and problems of the program to those present.

"Today's Health," the American Medical Association health magazine for lay readers, is being sent again this year to Florida's U. S. Senators and Representatives, the Governor and members of his cabinet and State Senators.

Your Committee has cooperated in every way possible on national legislation during the past year with the American Medical Association Committee on Legislation and the Washington Office.

Recommendation

It is recommended by your Committee that Chapter V Section 1 paragraph (57) of the Association's By-Laws be amended to read:

> *President Call Pre-Legislative Meeting* — That it become the policy of our Association for its president to call a joint meeting of the Board of Governors, Members of the House of Delegates, Bureau of Public Relations and the Committee on Legislation and Public Policy, approximately one year before the convening of the State Legislature for the purpose of planning a definite legislative program.

This changes the time of this meeting from sixty days prior to the convening of the legislature to approximately one year. This additional time will enable your Committee to present the program to the county medical societies well in advance of the legislature.

Your Committee desires to express its appreciation for the assistance given by the President, other State Association officers, Managing Director, Supervisor, Bureau

of Public Relations; to the officers and members of the legislative committees of the county medical societies, and to many individual doctors who have responded when called on for assistance.

Supplement

The problem of providing hospital and medical care for the indigent has been a major concern of the medical profession and is not one that can be solved by insurance. The American Medical Association believes that indigent medical care responsibility should be assumed by the local and state government. The A.M.A. Council on Medical Service has undertaken a series of studies of the organization and operation of state and local indigent medical care plans which are effective in meeting this need.

Means of providing hospital services for the indigent citizens of Florida are not available in many counties. Hospitalization costs for the indigent are frequently absorbed into general hospital expenses, and, therefore, increase the cost of hospitalization for all.

Those hospitals with medical postgraduate training programs could best provide care for the indigent if there were means of financing the costs, but all approved hospitals in the state could participate in the program.

A fund for indigent hospitalization could be provided by a state appropriation to be matched by each county in proportion to the county's population and per capita wealth.

An Indigent Hospitalization Commission should be appointed to study this universal problem as it specifically applies to Florida and make recommendations for a legislative act to provide hospitalization for the indigent.

Such a plan should not interfere with existing programs for the care of the indigent sick, such as the Crippled Children's Commission, Vocational Rehabilitation Service, Tuberculosis Board, State Mental Hospital, etc., and the primary responsibility for the care of the indigent sick should remain with the county government in cooperation with the medical profession. Counties should be given credit in the state fund for money spent for indigent hospitalization and county funds deposited in the state fund should be obtained from a part of certain revenues now distributed by the state to the counties. Great care should be taken that only the truly indigent receive hospitalization at taxpayers' expense.

Respectfully submitted,
H. Phillip Hampton, *Chairman.*

Recommendation

Therefore, it is recommended, that the Florida Medical Association through its Board of Governors, at its discretion, request the Governor of Florida to appoint a commission to study the problem of hospitalization of the indigent in Florida and make recommendations for a legislative act to provide hospitalization for the indigent.

Dr. Jelks: "The report of the Committee on Medical Education and Hospitals presented by Dr. Jack Q. Cleveland, Chairman, is approved as published in the Handbook. In studying the supplemental report, the Reference Committee recommends the substitution of the following for the recommendation on a new hospital in Gainesville:

"In lieu of any proposed new veterans psychiatric hospital in the state of Florida, the Florida Medical Association recommends that those veterans in need of neuro-psychiatric treatment be cared for in existing veterans hospitals. This opinion is based upon the fact that if medical care for veterans were restricted to those with service-connected disabilities and tuberculosis and neuro-psychiatric disorders, the existing veterans hospitals would be adequate to meet the need.

"I move that this substitute recommendation be adopted."

Seconded by Dr. George W. Morse.

Motion carried.

Dr. Jelks: "On the question of osteopaths, we recommend that the following be substituted:

"We recommend that until we have adequate knowledge of the standard of training in osteopathic schools as determined by proper educational authorities, the American Medical Association take no steps in the recognition of osteopaths.

"I move that this substitute recommendation be adopted."

Seconded by Dr. Eugene B. Maxwell.

Motion carried.

On motion made, duly seconded and carried, the Report of the Committee on Medical Education and Hospitals, with the supplemental report as amended, was approved.

Report of Committee on Medical Education and Hospitals

Jack Q. Cleveland, *Chairman*

The special assignment of this Committee is to urge gifts to the American Medical Education Foundation. Your Chairman has attended the three annual meetings of the Foundation in Chicago.

Our present records show that individual physicians and organizations allied to the Florida Medical Association have contributed $3,398 to the American Medical Education Foundation in the year 1953. This is not a large sum compared to some of the other state associations but we feel that as the value and need for the Foundation is realized by more of our members, the contributions will increase.

Your Chairman called a meeting of the full Committee in February to consider two important matters referred to this Committee by the Board of Governors.

The findings of the Committee will be given in a supplementary report to the House of Delegates in April. The two matters have to do with (1) an opinion on the proposal of the A.M.A.'s House of Delegates with reference to a report of the Committee for the Study of Relations between Osteopathy and Medicine and (2) a proposed Veterans Administration Hospital for neuropsychiatric patients to be located in Gainesville.

It has been a pleasure to serve as your Committee Chairman for the year, and I wish to thank all of the Committee members for their good work.

Supplement

At the request of several members of the Board of Governors, a meeting of the Committee on Medical Education and Hospitals was called. The meeting was held in Jacksonville on February 14, 1954 and a quorum was present.

Several hours were spent in discussing two matters referred to the Committee by the Board of Governors for recommendations.

The first matter was the proposed Veterans Administration Hospital for neuro-psychiatric patients in Gainesville, Florida. This problem was thrown into the lap of the Florida Medical Association when, last fall, Senator George Smathers proposed to Admiral Joel T. Boone, Chief Medical Officer for the Veterans Administration, that Florida could work out a formula for obtaining and keeping an adequate staff at this hospital and asked the Florida Medical Association for advice and counsel.

It is obvious, on the face of it, that staffing the proposed 1,000 bed (or even 500 bed) psychiatric hospital is an impossible task for the F.M.A.

Dr. Herpel wrote a very fine letter to Senator Smathers in connection with this proposal and your committee agrees unanimously with his feelings on the matter. We are all certain "that at this time there are not sufficient physicians trained in neuro-psychiatry to care adequately for the neuro-psychiatric needs of the general population in Florida."

It is the feeling of your committee that if only service-connected cases were cared for in the veterans hospitals, there would be ample room for the care of neuro-psychiatric cases in the already existing veterans facilities. It is a matter of record that for the past several years 85 per cent of the patients in veterans hospitals have been non-service-connected.

So, our recommendation to the Board of Governors and House of Delegates is:

Recommendation

In lieu of any proposed new veterans psychiatric hospital in the state of Florida, the Florida Medical Association recommends that those veterans in need of neuro-psychiatric treatment be cared for in existing veterans hospitals. This opinion is based upon the fact that if medical care for veterans were restricted to those with service-connected disabilities, tuberculosis and neuro-psychiatric disorders, the existing veterans hospitals would be adequate to meet the need.

The other question that your committee discussed at great length was the feeling of the Florida Medical Association in regards to the relationship between osteopathy and medicine. This was the most controversial issue brought before the House of Delegates at the meeting of the American Medical Association last June. Final action on this subject was deferred until the June 1954 session of the A.M.A. House of Delegates. Your committee feels that this subject will have to be discussed in our own House of Delegates to arrive properly at any decision. It is impossible for any committee to know how all the delegates feel about the matter.

Recommendation

We recommend that until we have adequate knowledge of the standard of training in osteopathic schools as determined by proper educational authorities, the American Medical Association take no steps in the recognition of osteopaths.

Respectfully submitted,
Jack Q. Cleveland, *Chairman*

Dr. Jelks: "The report of the Committee on Medical Economics presented by Dr. Reuben B. Chrisman Jr., Chairman, is approved as published in the Handbook. I move the report be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Report of Committee on Medical Economics

Reuben B. Chrisman Jr., *Chairman*

Your Medical Economics Committee has had no meetings during the past year. Most of the work which would ordinarily come to the attention of this Committee has been handled by the Board of Governors. In many respects this is more appropriate in view of the fact that the Board holds regular meetings, and subjects under consideration by such a Committee would normally be taken up for final action by the Board.

One subject was considered by members of this Committee and handled by correspondence with a recommendation to the Board of Governors. Such subjects as Association Employee Retirement, Malpractice Insurance, and Annuity plans should, in the Committee's opinion, be given serious consideration during the coming year. Much preliminary study has been accomplished by some county societies within the state.

Your Chairman wishes to express his appreciation to the members of this Committee for their assistance.

Respectfully submitted,
Reuben B. Chrisman Jr., *Chairman*

Dr. Jelks: The report of the Committee on State Controlled Medical Institutions presented by Dr. Samuel G. Hibbs, Chairman, is approved with two recommended changes:

1. That recommendation 3 be deleted because of lack of understanding by members of this committee of the exact intent and thought of the author.
2. That the word 'additional' in the 4th recommendation be changed to read 'sufficient.'

"I move that this report be adopted as amended."

Seconded by Dr. Herbert E. White.

Motion carried.

Report of Committee on State Controlled Medical Institutions

Samuel G. Hibbs, *Chairman*

The following report is based upon personal visits to the Arcadia branch of the Florida State Hospital and the Florida Farm Colony at Gainesville this past month. As I have visited the Florida State Hospital at Chattahoochee on numerous occasions and recently received a very adequate report from Dr. William D. Rogers, Superintendent, I did not visit Chattahoochee during the past few months.

Dr. Rogers reports that legislative appropriations have been continued for new buildings at the Florida State Hospital at Chattahoochee for both male and female, Negro and white patients. He also reports that the psychiatric staff has been enlarged to 19 physicians. The addition of a psychiatric social worker, three psychologists and considerable expansion of the occupational therapy program with additional trained personnel is very commendable.

At the Arcadia branch there has been sufficient money appropriated to increase the bed capacity from 1,100 to approximately 1,700 beds. The two institutions at Arcadia, which incidentally are 15 miles apart, are very well kept and the food served the patients was well prepared and that of a balanced diet. Until recently, however, there was only one doctor who could qualify as a psychiatrist for 1,100 patients, and there was a lack of other professional personnel such as psychologists, psychiatrically trained social workers and laboratory technicians. There is definitely a need for more psychiatrists at Arcadia, and a more extensive occupational therapy program headed by a trained occupational therapist, particularly for the men, is needed. It is believed that a much more active farm program could be utilized by both the male and female sections of the Arcadia branch than exists at the present time.

The visit to the Florida Farm Colony at Gainesville with Dr. James G. Lyerly proved to be very interesting and instructive. The Farm Colony is in the midst of a building program which includes facilities for the first time for taking mentally retarded and epileptic Negro children. They are enlarging their academic school program and are planning to increase their occupational and recreational facilities. The addition of a qualified psychiatrist would be a great help to their program. It is also believed that there should be a closer liaison between the Psychology Department of the University of Florida and the Farm Colony.

It should be noted that the legislature during its 1953 session appropriated $5,000,000 for the construction of a

new psychiatric hospital to be located in Broward County near the Dade-Broward line. The plans are being drawn and it is hoped that in six to eight months construction will begin. It is felt that a medical director, who has not only administrative ability but who is also a trained qualified psychiatrist, should be employed immediately so that he can become thoroughly familiar with the plans and give advice where it would be needed. It should also be noted that over $500,000 has been made available by the preceding legislature for an alcoholic rehabilitation program in the state. Clinics for out-patient treatment should be approved and set up in various large, populated areas.

I feel the physicians of Florida can think with reasonable pride of their state controlled medical institutions but the following recommendations are made by your Chairman concerning these institutions:

1) That no new construction which will increase the patient population at the Florida State Hospital at Chattahoochee be approved;
2) That greater efforts be made to obtain physicians and encourage them to become Diplomates in the American Board of Neurology and Psychiatry in Psychiatry;
3) (Deleted)
4) That sufficient professional aids be employed at the Arcadia branch and the Florida Farm Colony;
5) And finally that any proposed future state controlled medical institutions be located within 30 to 40 miles of the large populous areas so that the institutions will have the advantage of a consulting staff and can better obtain other professional help and employees.

Respectfully submitted,
Samuel G. Hibbs, *Chairman*

Dr. Jelks: "The report of the Committee on Representatives to Industrial Council by Dr. Frank L. Fort, Chairman, is approved as published in the Handbook. In view of the report, that the committee has had no designated duties or requests for any type of service, it is recommended that this committee be discontinued."

Dr. Herpel: "I would like to have separate action on these two items, first on the report of the committee, and then on the recommendations of the Reference Committee. The proposal to discontinue this committee is one that no one has had time to study. I have no doubt this committee was set up largely to perform a certain function and there will be years in which this committee has little to do. There may be other times in which it may have very significant activities. If there is no objection to dividing the question, I would like for you to vote first on the report."

Dr. Jelks: "I move the adoption of the report as printed in the Handbook."

Seconded by Dr. Ralph Herz.

Motion carried.

The Chair recognized Dr. Duncan T. McEwan.

Dr. McEwan: "I do not approve of the abolishment of this committee. During the past year, the chairman of this committee left the state for postgraduate work and the chairmanship was placed in the hands of another man. I do not think the committee had a fair chance to function and I feel that this committee should be carried on."

The Chair recognized Dr. Samuel M. Day.

Dr. Day: "Actually, according to the By-Laws, the duties of this committee shall be to represent the Florida Medical Association at meetings of the Industrial Council. We use this committee occasionally because there is so much industrial medicine today."

Dr. Frankln J. Evans rose to a point of order: "Is it within the purview of this body to abolish a committee of this type without certain constitutional proceedings?"

Dr. Herpel: "I would say from my own standpoint that it would be questionable that we take up the abolishing of a committee unless it had been mentioned in the first meeting of the House of Delegates and an opportunity given to all those who might be interested to be heard on the subject.

"I would, therefore, rule that it is not strictly legal to act on the matter at this meeting."

Dr. Homer L. Pearson Jr.: "I move that the recommendation of the committee be not accepted."

Seconded by Dr. Julius C. Davis.

Dr. Herpel: "Those in favor of disapproval of the recommendation of the Reference Committee—"

Dr. Franklin J. Evans: "Dr. Pearson's motion was out of order, too."

Dr. Herpel: "You are correct, Dr. Evans. May I clarify this by reading Chapter XII, paragraph (117) of the By-Laws.

> *These By-Laws may be amended at any Annual Meeting by a majority vote of all the Delegates present at that meeting after the amendment has laid upon the table for one day.*

"Therefore, the whole question is out of order and we will simply drop it."

Report of Representatives to Industrial Council

Frank L. Fort, *Chairman*

Since assuming chairmanship of this Committee following the resignation of Dr. Fred H. Albee Jr. of Orlando, no requests of any kind have been made of this Committee. With no designated duties or requests for any type of service, the Committee has not functioned as such.

It seems doubtful whether there is reasonable justifica-

tion for the continued existence of this Committee.

Respectfully submitted,
Frank L. Fort, *Chairman*

Dr. Jelks: "The report of the Committee on Grievance is approved as presented by Dr. Walter C. Payne Sr., Chairman, and published in the Handbook, with an expression of appreciation to Dr. Payne for an unpleasant job well done. I move it be adopted."

Seconded by Dr. Shaler Richardson.

Motion carried.

Report of Grievance Committee

Walter C. Payne Sr., *Chairman*

The Grievance Committee is one of the newest, if not the newest, of the standing committees of our Florida Medical Association. This is the fourth year of its operation and it is only natural that we should pause to evaluate its usefulness. It may be that your Chairman is prejudiced, but with the passing of time he feels more and more that the Committee, with its system of county mediation committees, is well worth while.

The mere fact that our Association has such a committee, in my opinion, has had a very beneficial effect both on the lay public and upon our own members. It is doing much to restore confidence in the integrity of our profession and to regain the prestige which we have lost in the last few years. It is apparent that the existence of our grievance and mediation committees has had a restraining influence on the very small minority of our members who have been tempted to disregard our high ideals and ethical conduct.

I think the above statements are borne out by the fact that we are receiving fewer complaints, and that of those we do receive, a larger percentage than formerly are received from psychotic individuals or are trivial in character. In the beginning of our operation, a considerable percentage of the complaints received were well founded and reasonable. We still receive some complaints which fall in this category but the percentage of justifiable complaints is getting smaller each year. I believe we can reasonably assume that this is no accident, but to a large extent is due to the inhibiting influence of the grievance committees.

Your Chairman, as in former years, would like again to stress the importance of prompt and courteous treatment of every complaint. Any unnecessary delay in processing a complaint decreases the chance of handling the complaint to the satisfaction of the complainant, and a prolonged delay is absolutely disastrous. I would like to appeal to the county mediation committees to handle every complaint, however trivial, in such a manner that the complainant will feel that he or she has been fairly treated. The manner of handling a complaint should convince the instigator that it is not the purpose of our committee to "whitewash" nor condone any misconduct of our members.

Your Chairman would like to emphasize the importance of the county mediation committees keeping the state Committee informed of the negotiations and progress being made on each case being handled.

I would like to express appreciation to the mediation committee chairmen for their cooperation.

Respectfully submitted,
Walter C. Payne Sr., *Chairman*

Report of Reference Committee No. 3

Dr. Duncan T. McEwan, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the report of that committee.

Dr. McEwan: "Reference Committee No. 3 met with all members present as follows: Drs. Samuel M. Day, Francis H. Langley, Warren W. Quillian, Walter C. Payne Sr., and your chairman.

"The first thing we considered was the resolution by the Sarasota County Medical Society on consideration of some city other than Hollywood for the annual meeting. This resolution was approved as published in the Handbook and I move that it be adopted."

Seconded by Dr. Sappenfield.

Motion carried.

Resolution

WHEREAS, during the past few years many members of the State Society have been dissatisfied with the locale of the Annual Meeting; and

WHEREAS, more and more members are apparently not attending the meeting because of the locale;

BE IT RESOLVED that an active effort be made by the State Society to consider some city other than Hollywood for this important Annual Meeting.

Respectfully submitted,
Lloyd J. Duest, *Secretary*
Sarasota County Medical Society

Dr. McEwan: "The resolution on entertainment for the 1954 Clinical Session of the American Medical Association in Miami, presented by Dr. Homer L. Pearson Jr., Chairman on Arrangements, was approved as read. I move it be adopted."

Seconded by Dr. L. Washington Dowlen.

Motion carried.

Dr. Pearson:

The Clinical Session of the American Medical Association will be held in Miami, November 29, 30, December 1, 2, 1954, with the Florida Medical Association and the Dade County Medical Association as hosts.

We in Dade County are most anxious to make this the most successful Clinical Session since its inception. We are sure you of the Florida Medical Association are just as anxious for a successful meeting.

To insure success it will be necessary for all of us to work together to that end. Let me first remind you that to insure success for this meeting you must attend. Every member of the Florida Medical Association must make every effort to attend and enter into the activities of the convention. We will also need your help in planning and in carrying out the plans for the meeting, and to successfully entertain those attending we must have your financial assistance. Therefore, with your approval I would like to present the following resolution to the House of Delegates:

Resolution

WHEREAS: The Clinical Session of the American Medical Association will be held in Miami November 29, 30, December 1, 2, 1954, and

WHEREAS: It has been the custom down through the years, when the American Medical Association holds its convention in any city, that both the constituent association and the component society so honored have joined together to afford the visitors the best entertainment which the locality has to offer, and

WHEREAS: The entertainment at the Annual Session is usually much more extensive than at the Clinical Session, however, since this is the first time the convention has been held in Florida, we, of the entertainment committee,

feel that since the facilities are so great in Florida for entertainment, that we should endeavor to put on a convention which would not be soon forgotten by those attending, and

WHEREAS: To do this we will need the financial aid of the Florida Medical Association, and

WHEREAS: We are making every effort to finance this project through other sources. We realize that any monies appropriated by the Florida Medical Association are funds from members of the Dade County Medical Association as well as from all other members of this Association, and we are as anxious to be as saving as you are, and

WHEREAS: We will make every effort to furnish first class entertainment for the very lowest cost,

BE IT THEREFORE RESOLVED that the House of Delegates of the Florida Medical Association appropriate at least five thousand dollars ($5,000.00) for the entertainment of the members of the House of Delegates, the officers, councils and committee members of the American Medical Association and their wives.

Respectfully submitted,
Homer L. Pearson Jr., *Chairman*
Committee on Arrangements

Dr. McEwan: "The resolution on holding the 1955 Annual Meeting in Nassau, presented by the Broward County Delegation, is not approved.

"We had three representatives from Nassau who painted a very nice picture and it seemed very alluring, although we did not see their movies; but they did not have enough information so that we could make a decision. Later on we are going to recommend that the next meeting be held in St. Petersburg.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Frazier J. Payton.

Motion carried.

Dr. McEwan: "On the report of the Board of Governors as presented by Dr. Frederick K. Herpel, Chairman, I would like to take up the report and its two supplements separately.

"The report as published in the Handbook is approved with the following amendment: That the recommendation for the place of the 1955 Annual Meeting be changed from Hollywood to St. Petersburg. The committee feels that in view of current trends in convention booking, it would be good policy for the Board of Governors to investigate sites for future meetings two or more years in advance. I move this report be adopted as amended."

Seconded by Dr. Wilson T. Sowder.

Motion carried.

Dr. McEwan: "The supplemental report of the Board of Governors is approved with two amendments: (1) that the third paragraph be deleted, and (2) that the House of Delegates approve the American Medical Association's policy statement on medical care for veterans with non-service-connected disabilities.

"I move that this supplemental report, as amended, be adopted."

Seconded by Dr. Frederick H. Bowen.

Motion carried.

Dr. McEwan: "The supplemental report on Liaison to the Board of Governors on Public Relations is approved as read, with commendation to the chairman and his advisory committee for a job well done, and for the broad policy that they have envisioned for future work.

"I move that this supplemental report be adopted."

Seconded by Dr. Frazier J. Payton.

Motion carried.

Dr. McEwan: "The recommendation for a constitutional amendment on the selection of a place for the annual meeting, presented by the Board of Governors in its supplemental report, is approved. I move it be adopted."

Seconded by Dr. Eugene B. Maxwell.

Motion carried unanimously.

Dr. McEwan: "We have voted on each portion of this report. I now move that the report of the Board of Governors and its two supplements, as amended, be approved."

Seconded by Dr. Edward W. Cullipher.

Motion carried.

Report of Board of Governors

Frederick K. Herpel, *Chairman*

Three meetings of the Board of Governors were held as follows: April 29, August 23 and November 22, 1953. An expression of gratitude is due the members of the Board, many of whom travel great distances at their own expense to attend these meetings.

Recommendation — By-Law Changes

Your Board recommends:

That Chapter VII, Section 7 of the By-Laws be amended to read:

"The President shall appoint, with the approval of the Board, either one of the Board members as Liaison on Public Relations between the Board and the Executive Office or a non-member of the Board who shall then be a Board member for a term of one year."

That Chapter VII, Section 1 be amended by deleting in lines 7 and 8: "a Committee on Public Relations (Section 7)" and substituting therefor: "a Liaison on Public Relations between the Board of Governors and the Executive Office (Section 7)."

That Chapter VII, Section 2 be amended by inserting after the word "year" in line 14: "The President may appoint with the approval of the Board, one additional member who shall then serve as Liaison on Public Relations between the Board and the Executive Office."

Your Board, after careful deliberation and study has decided that this proposed change with reference to Public Relations would increase the efficiency and effectiveness of this phase of Association activities. The Executive Office, which includes the Public Relations Bureau, assists

the officers and the several committee chairmen in carrying out programs. The Bureau of Public Relations devotes considerable time to assisting the Committee on Legislation and Public Policy. It is obvious that at times the necessity arises to determine the priority of certain projects or programs in order to enable the Bureau to give the desired assistance in the correct sequence. If these changes are approved, the Board will pass on major policies and it will then be the duty of the member serving as Liaison to carry out the instructions of the Board and to direct the implementation of the program. During the past year, with the approval of the chairman of the Committee on Public Relations, this method has been in effect on a trial basis with Dr. Edward Jelks serving as Liaison on Public Relations for the Board. The results have been most satisfactory and substantiate the wisdom of the decision to make this change.

Recommendation — By-Law Changes

Your Board further recommends that Chapter V, Section 5, be amended by deleting after the word "Journal" in line 25: "In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum."

Your Board further recommends that Chapter VII, Section 5, be amended by deleting after the word "Association" in line 10: "The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal."

These recommendations are made to delete these obsolete portions of the By-Laws. Neither your secretary nor your editor is accepting the stipulated sums nor have they been accepted since the early days of the Association when the Secretary-Treasurer and Editor were required to do much of the detail work now being handled in the Executive Office.

Recommendation — Annual Meeting

That St. Petersburg be designated as the meeting place for the 1955 Annual Meeting. The By-Laws provide that the dates for the meeting shall be set by the Board of Governors.

The dates for the Eightieth Annual Meeting in Hollywood were set for April 25-28, 1954.

An operating budget for the fiscal year beginning April, 1953, was presented by Dr. Samuel M. Day, Secretary-Treasurer, and approved.

Mr. Ernest R. Gibson was unanimously approved by the Board to serve as Acting Managing Director to fill the vacancy created by the death of Dr. Stewart G. Thompson.

The following members, on recommendation of their local county medical societies, were elected to Honorary Memberships: Drs. Joseph B. Kollar, Leander J. Graves, Lawrence A. Cleverdon, George E. Stevens, John Bell Matthews and Charles Kirby Smith.

A special committee comprised of Drs. Robert B. McIver, Samuel M. Day, Duncan T. McEwan and Edward Jelks, was appointed to investigate a retirement program for employees of the Association.

Two problems presented to the Board were referred to the Committee on Medical Education and Hospitals.

1. To make a study and recommendations with reference to a request from the American Medical Association's Committee for the Study of Relations between Osteopathy and Medicine.
2. A recommendation by Senator George A. Smathers that a Veterans Administration hospital for neuropsychiatric patients be constructed at Gainesville.

Your Board approved in principle a proposal by the Marion County Medical Society to establish a memorial to the late Dr. Stewart G. Thompson. Dr. Richard C. Cumming, Ocala, was authorized to develop this idea. Dr. Cumming traveled to each of the four Medical District Meetings in October at his own expense to explain his proposal to the members.

A contribution to the American Medical Education Foundation in the amount of $5 for each deceased past-president of the Association was approved and forwarded to the Foundation. It was the unanimous opinion of the Board that this would be an appropriate tribute to the memory of these men for their contributions to the medical profession.

Your Board carefully considered and approved the schedule to be followed at the Eightieth Annual Meeting. This program is published in the March Journal and in the printed program.

The Board gave unanimous approval to your President's request to urge each county medical society to establish a Committee on Veterans Medical Care.

The instructions of the 1953 House of Delegates for further study of the report of the Medical Postgraduate Course Committee have been complied with, and instructions have been forwarded to the chairman of this committee.

Sub-Committee to Board of Governors on Veterans Care

The efforts of this committee during the past year have been directed toward getting the Veterans Administration to stop treating non-service-connected disabilities. We feel that the Veterans Administration should not treat non-service-connected disabilities with the exception of neuropsychiatric disturbances and tuberculosis. On November 8, a Regional Conference was held in Atlanta concerning this problem. Dr. Louis M. Orr, Chairman of the A.M.A. Committee on Federal Medical Service, presided at the meeting. The meeting was attended by President Frederick K. Herpel, Dr. George M. Stubbs and your Chairman. Representatives from Miami, Fort Myers and St. Petersburg were also present. It was the consensus at that meeting that the doctors of Florida should be educated concerning the dangers of treatment of non-service-connected disabilities by the Veterans Administration and that the public should subsequently be informed of this problem and its dangers. Following this, we should attempt to get legislative action through the Congress which would provide that the Veterans Administration would not be permitted to treat non-service-connected disabilities.

On November 24, a letter from your President went out to the president of each county society urging that a committee on veterans care be appointed in each county medical society. Twenty-four counties have responded noting the membership of their committees.

Frederick H. Bowen, *Chairman*

Sub-Committee to Board of Governors on Advisory to National Foundation Infantile Paralysis

In April 1953 a meeting of the Polio Planning Committee was held in Jacksonville. This meeting was attended by Dr. Richard G. Skinner Jr., a member of the Committee, and your Chairman. Dr. Skinner was appointed chairman of the Polio Planning Committee. The use of Gamma Globulin in the prophylaxis of poliomyelitis was discussed.

On Dec. 9, 1953, a meeting of the National Foundation for Infantile Paralysis was held in Jacksonville. This meeting was attended by Dr. Richard G. Skinner Jr. The Foundation hopes to raise $75,000,000 this year, of which $28,000,000 will be expended on patient aid, and $26,000,000 for the prevention of poliomyelitis. Of this latter amount, $19,000,000 will be used for Gamma Globulin, and the remainder will be used for immunization with the polio vaccine devised by Salk. Remaining funds will be divided between research and public information, and miscellaneous expenditures.

Beginning in February 1954, an active immunization program will be begun in selected counties using Salk's vaccine. This vaccine will be given under the supervision of local health officers, by the local physicians in teams and it will be administered at the schools. The purity and safety of the vaccine is to be checked by bacteriologic and tissue culture, and by injections into monkeys. Before a program is instituted in a county, advance publicity will be given in forms of films and lectures.

Frederick H. Bowen, *Chairman*

Sub-Committee to Board of Governors on Review of Fee Schedules

During the past year the Fee Schedule Committee has not held any formal meetings. However, there has been considerable correspondence among its members and also quite a few informal discussions in reference to fee schedules.

We might summarize the activities of the past year by saying that the Committee has been busy formulating methods as to how we can properly coordinate all the state agencies into one central fee schedule similar to the one previously accepted by a federal agency. Special ground work has been made and a firm foundation established so the new Committee can contact proper counsel for advice and guidance in obtaining a unified fee schedule for all state agencies.

John D. Milton, *Chairman*

Liaison to Board of Governors on Public Relations

The primary activity of your liaison officer has been the development of a long range public relations program for our Association. This program is based upon broadening the scope and implementation of the many activities being conducted at the present time.

In planning the Public Relations Program an attempt has been made to devise methods to assist in the improvement of (1) the individual physician's relationship with his patients and fellow physicians; (2) through individual and group action to provide the public with the finest medical care possible and (3) to inform the public of this service. The program in detail will be submitted in a supplemental report.

An Advisory Committee composed of public relations chairmen of five county medical societies, to be rotated as warranted, has been established to promote a well rounded program over the entire state.

This report would not be complete without an expression of appreciation to the Association's officers, individual members and executive office staff for their cooperation in preparing our program.

Edward Jelks

Sub-Committee to Board of Governors on Blue Shield

Blue Shield of Florida, Inc., had a very successful year in 1953. The Plan completed the year with 336,438 subscribers. This is a net increase for the year, over and above cancellations, of 66,426 subscribers, or an increase of 24.6 per cent. During the year, the Plan paid 74,203 claims amounting to $2,412,511, an increase of 20,560 claims or 38.3 per cent. The increase in payments to doctors was $654,756.25, or an increase of 37.3 per cent. After payment of claims and 11.7 per cent for operating expenses, the Plan was able to add to its reserve $365,827.10, or 11.4 per cent.

The Board of Directors voted to increase medical payments beginning March 1, 1954, as follows:

> Payment for in-hospital medical care to begin on the third day of the hospital confinement instead of on the fourth day as is presently provided.
>
> Seven dollars a day to be allowed for each daily hospital visit from the third through the ninth days of hospital confinement with $5 per day for each day thereafter up to a maximum of $250, in place of the present $5 daily visit allowance.

The Board of Directors also voted to increase the income limitations effective March 1, 1954, from $2,000 to $2,400 for single people and, from $3,000 to $3,600 for families. At the same time these changes were made, the medical doctor was asked to agree not to charge the low income group more than $7.00 a day for the first two days of in-hospital medical care that is not covered by Blue Shield.

The Plan is looking forward to continued growth in 1954.

Leigh F. Robinson, *Chairman*

Supplement

This supplement to the Report of the Board of Governors is in addition to, and a part of, the original report as printed in the Handbook. It is submitted to include a meeting of the Board in Jacksonville on March 28.

On January 21, 1954, the Secretary, Dr. Samuel M. Day, wrote to the secretary of each county medical society directing attention to Chapter VII, Sec. 2, paragraph (70) of the By-Laws which provides for presentation to the Board of invitations for the place of the Annual Meeting. In response to this letter, an official invitation was received from the Secretary of the Pinellas County Medical Society to hold the 1955 Annual Meeting in St. Petersburg. No other invitation was received for 1955.

Recommendation—Constitutional Amendment

Your Board recommends:

That Article VI, Sec. 2, paragraph (12) of the Constitution be amended to read:

"The Association shall hold an Annual Meeting at the place selected by the House of Delegates. The date of such meeting shall be fixed by the Board of Governors."

Your Board believes it is advisable to make this constitutional change in order that the site of the Annual Meeting can be determined more than one year in advance. It has become increasingly difficult to have the most desirable dates for the Annual Meeting when it is not possible to make a definite commitment to hotel officials more than one year preceding the date of the meeting. Hotels are booking conventions two to three years in advance.

At the meeting of the Second House of Delegates in 1953, the Board of Past Presidents recommended that the Board of Governors consider the advisability of holding the Association's Annual Meeting on Thursday, Friday and Saturday with the specialty groups holding their meetings Saturday afternoon and Sunday, instead of the present arrangement. President McIver referred this to the Special Committee on Scientific Assembly and Specialty Group Problem, Dr. Herbert E. White, Chairman.

On the basis of the report from Dr. White's committee and the sentiments expressed by the members of the Board, it is recommended that the days of the week during which the Annual Meeting is held remain as they now are.

Your Board took under consideration a request of the American Medical Association's House of Delegates that each state medical association "take formal action approving the policy statement on medical care for veterans with non-service-connected disabilities." Your Board believes that the House of Delegates should approve this policy.

The policy statement referred to is as follows:

> "Because the AMA believes that consideration of these problems must be predicated upon concern for the health and welfare of the entire population and not just a particular segment, the AMA's House of Delegates, in June, 1953, recommended that the Congress enact legislation limiting VA medical care and hospitalization benefits to:
>
> "(a) veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated, and to
>
> "(b) veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expense of necessary hospitalization, provided that treatment is given within limits of existing facilities."

Your Board approved the report of a Special Committee, Dr. Robert B. McIver, Chairman, which recommended that a retirement program be established for employees of the Association.

Your Board accepted the report of the Committee on Medical Education and Hospitals, Dr. Jack Q. Cleveland, Chairman, with reference to a proposed Veterans Administration Hospital for neuropsychiatric patients in Gainesville, and the request from the AMA for an expres-

sion of opinion on the relationship between osteopathy and medicine. The recommendations of this committee are contained in Dr. Cleveland's supplementary report which has been referred to Reference Committee 2, Public Policy.

Your Board is fully cognizant of the great honor that comes with the holding of the AMA Clinical Session in Miami in December, 1954. It has indicated its interest and its desire to assist in any way possible to the General Chairman on Local Arrangements, Dr. Homer L. Pearson Jr. It has further asked Dr. Pearson to submit specific requests for what assistance he desires from the Florida Medical Association, so that such requests may be submitted to this House in the form of a supplementary resolution.

The following members, on recommendation of their local county medical societies were elected to Honorary Membership: Drs. Lewis W. Glatzau, Carol C. Webb, Otis Marshall, Lockland V. Tyler, Leland H. Dame.

Supplement

Public Relations Liaison

The Florida Medical Association was founded eighty years ago. Since that time, innumerable changes have altered the philosophy and practice of medicine. These changes have combined with the multitudinous changes in every phase of life to create our complex society of today, with its tremendous medical public relations problem.

A simple definition for good public relations is "To do good, to be good, and to tell others about it." This is our objective.

When we analyze the opinion surveys sponsored by medical societies in various areas of the nation, the letters received, and the newspaper and magazine articles expressing how others feel toward our profession, we find the main areas where criticism arises are:

1. Availability of medical care.
2. Cost of medical care.
3. Impersonal attitude and aloofness of too many in our profession.
4. Failure by us to assume community responsibilities.

Through broadening the scope of our many past activities and applying sound public relations principles, we are developing a long range progressive program. We trust it will be worthy of approval by every county medical society and individual physician.



Board of Governors

Florida Medical Association

Front row, left to right, Louis M. Orr, Orlando; Frederick K. Herpel, West Palm Beach; President-elect John D. Milton, Miami; President Duncan T. McEwan, Orlando; Secretary-Treasurer Samuel M. Day, Jacksonville.

Back row, left to right, Meredith Mallory, Orlando; Herbert L. Bryans, Pensacola; William C. Roberts, Panama City; Robert B. McIver, Jacksonville; Norval M. Marr, St. Petersburg; Edward Jelks, Jacksonville; Russell B. Carson, Fort Lauderdale.

In order to maintain the best public relations for our profession, we present the following dynamic program:

1. MEDICAL CARE FOR ALL
   a. Guarantee the services of a physician or surgeon to every person needing them.
   b. Expand the network of emergency call services, in some form, to provide the people of every community with the services of a physician in an emergency.
   c. Promote the concept of a personal physician, so that people may have someone to accept total and continuing responsibility for administering or securing and supervising care of all their medical and surgical problems.
   d. Cooperate and sponsor with other agencies adequate care of the medically indigent of our state.
   e. Promote the expansion of hospital facilities in communities to eliminate deficiencies where they exist.
   f. Actively aid communities trying to attract physicians, with the ultimate goal of every area having access to the services of a physician.
   g. Promote the improvement of rural health through encouraging individual and community action to determine and solve the health problems of the respective communities with the resources available.
   h. Cooperate in developing our grievance committees into strong and fearless bodies to hear patients' complaints, and discipline the very few among us who bring discredit upon our entire profession.
2. PAYING FOR MEDICAL CARE
   a. Promote friendly and frank discussion of fees and related services between doctors and patients to avoid misunderstandings and enlighten the public on costs of medical care.
   b. Promote the extension and development of voluntary health insurance to meet the needs of the public to pay the costs of illness.
   c. Promote medical society sponsorship of Budget for Health Plans or financing health care on a prepayment basis.
3. INFORMATION AND EDUCATION
   a. Medical forums to present authoritative health information to the general public.
   b. Feature articles in the public press to inform the readers of organized medicine's role in meeting the health needs of each community.
   c. Radio and television programs.
   d. Active speakers' bureaus.
   e. Fair exhibits and displays.
   f. Press-radio-television conferences and codes of cooperation.
4. WORKING WITH OTHERS
   a. Coordination with the Woman's Auxiliary to promote our public relations objectives.
   b. Liaison and cooperation with allied groups. (Dentists, druggists, nurses, medical assistants, medical technicians, etc.)
   c. Liaison and cooperation with other professional groups. (Ministers, attorneys, etc.)
   d. Active participation by physicians in civic organizations and community projects.
   e. Advisory and liaison relationship with organized labor.
   f. Coordination and planning with state and independent agencies to maintain high health standards for the people of our state.
5. MEDICAL SOCIETY UNITY
   a. Promotion of active participation and interest in affairs of organized medicine by all members.
   b. Indoctrination of members, interns, residents and medical students to the problems and programs of organized medicine pertaining to governmental medicine and socioeconomic affairs. (Veteran's medical care, extension of social security coverage, etc.)

Many phases of our program have been and are now being carried out to a varying degree. Throughout the state, county medical societies have made outstanding progress in public relations through numerous activities of service to the public. We wish to compliment you on your fine work.

Your Association, through its Bureau of Public Relations, has personnel and facilities to promote and coordinate the public relations program. You are encouraged to call upon the Bureau to assist and advise with your local programs. Its representatives have visited and worked with the officers and committee chairmen of every component county society and have been most diligent in the discharge of their duties. The staff of the Bureau is to be highly commended for its varied activities during the year now closing. An account of the Bureau's activities will appear in the annual report of the Secretary-Treasurer and Acting Managing Director.

The Public Relations Committee Chairmen of five county medical societies have been asked to serve in an advisory capacity on a state level this year, to assist in implementing our program and lend their talents to improving our profession's public relations. They are Drs. Robert F. Dickey, Dade County Medical Association; Francis T. Holland, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society; G. Dekle Taylor, Duval County Medical Society; Eugene B. Maxwell, Hillsborough County Medical Association; and Don C. Robertson, Orange County Medical Society.

As the representative of the Board of Governors for Public Relations, I welcome, at all times, constructive suggestions and criticisms by any member of the Association, for we need your support and advice to carry out the tremendous task ahead of us.

Respectfully submitted,
Edward Jelks

Your Chairman wishes to take this opportunity to express personal appreciation to the members of the Board for their excellent cooperation and for the careful consideration with which they weighed matters which have come to the attention of the Board.

Respectfully submitted.
Frederick K. Herpel, *Chairman*

Dr. McEwan: "The report of the Committee on Public Relations presented by Dr. Leigh F. Robinson, Chairman, is approved, with an expression of appreciation to Dr. Robinson for his cooperation in the formation of the Liaison to the Board of Governors on Public Relations.

"I move the report be adopted."

Seconded by Dr. Jere W. Annis.

Motion carried.

Report of Committee on Public Relations

Leigh F. Robinson, *Chairman*

The report on public relations is contained in the report of the Public Relations Liaison to the Board of Governors.

Respectfully submitted,
Leigh F. Robinson, *Chairman*

Dr. McEwan: "The report of the Committee on Necrology with its supplement, presented by Dr. Alvin L. Stebbins, Chairman, is regretfully accepted with the following amendment: That the name of Dr. Walton C. Touchton be added. I move that this report be adopted."

Seconded by Dr. Ralph Herz.

Dr. Herpel read the names of the members who have died in the past year.

The House of Delegates stood for a moment of reverent silence.

Report of Committee on Necrology

Alvin L. Stebbins, *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Neil Alford, Jacksonville
Oliver P. Broadbent, Jacksonville
Alan Brown, Clearwater
John H. Cooper, Commerce, Ga.
Edmonson S. Couric, Miami
Raymond J. Dalton, Key West
Alvin Q. English, Palmetto
Meyer J. Glick, Miami Beach
Banks H. Goodale, Jacksonville
Thaddeus H. Green, St. Petersburg
Roger W. Gridley, Orlando
James C. Griffin, Tampa
Helen I. Grove, Largo
Henry Hanson, Jacksonville
Donald W. Hedrick, Tampa
Howard G. Holland, Leesburg
Luther W. Holloway, Jacksonville
Whedon Johnson, Sarasota
Geo. N. MacDonell, Miami
Arthur P. MacVeany, Miami
Thomas C. Maguire, Plant City
Max R. Mansfield, Coral Gables
A. George Meister, Sarasota
Joseph S. Murrow, Apalachicola
John K. Norwood, Jacksonville
Lewis Palay, Miami Beach
S. Joseph Pearlman, Miami Beach
Clyde F. Smith, Miami Beach
H. Mason Smith, Tampa
Samuel F. Smith, Lakeland
Walker E. Swift, Sarasota
Rufus Thames, Milton
Gerald J. Walsh, Miami
Eston D. White, Miami
John F. Wilson Jr., Lakeland

Supplement

John R. Boling, Tampa
Otis W. Britt, Tallahassee
John E. Granade, Bradenton
Raul Roque de Escobar, Tampa
Dwight I. Roush, Pinellas Park
Samuel B. Strong, Lake Charles, La.
Walton C. Touchton, Avon Park

When possible, obituaries have appeared in The Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

May we at this time stand for a moment of silence in reverence and respect to the memory of our departed colleagues.

Respectfully submitted,
Alvin L. Stebbins, *Chairman*

Dr. McEwan: "The report of the Committee on Advisory to Woman's Auxiliary presented by Dr. C. Robert DeArmas, Chairman, is approved as published. I move the report be adopted."

Seconded by Dr. Edward Jelks

Motion carried

Report of Committee on Advisory to Woman's Auxiliary

C. Robert DeArmas, *Chairman*

The Committee on Advisory to the Woman's Auxiliary to the Florida Medical Association did not hold any meetings during the year 1953.

I am happy to report that the Woman's Auxiliary continues its excellent work and progress.

Respectfully submitted,
C. Robert DeArmas, *Chairman*

Dr. McEwan: "The report of the Committee on Councilor Districts and Council, with its supplement, is approved. I move the report be adopted."

Seconded by Dr. L. Washington Dowlen

Motion carried.

Report of Council

John D. Milton, *Chairman*

The first meeting of the Council was held during the annual meeting of the Florida Medical Association so that each Councilor might become acquainted, and so as to orient each as to their duties. Soon after the meeting, our role as "peacemakers" began. Our desire was to make each and every component society a stronger unit.

During the summer it was learned that the doctors in Hamilton and Lafayette Counties had expressed desires that they be placed under the supervision of Suwannee County instead of Columbia. The Council heartily recommends that Suwannee County Medical Society incorporate Hamilton and Lafayette Counties into their Society, inasmuch as it works a hardship on the individuals in these two counties to meet with the Columbia County Medical Society, or the Taylor County Medical Society.

The District Meetings that were arranged by the Council for October 1953, as published in the Florida Medical Journal, October, pages 258 and 259, were very well attended and the scientific program was well received in each district. The total registration at the four meetings was 340. As usual, state officers were present and at each of the meetings gave interesting talks in reference to the action of the Association. I might say here that the "old standby," Bob McIver, was present at each and every meeting.

This has been a very interesting year and I am certain that the Council as a whole, and most certainly myself, consider it a pleasure and a privilege to work for the good of the State Association and give our best in reference to more harmonious and stronger component societies and, in turn, a stronger State Association. In retiring as the Chairman of the Council, I wish to compliment each of the Councilors for their untiring effort and great cooperation, because I assure you that no Committee and more especially the Council cannot function unless each individual member does his part; therefore, my hat is off to the Councilors, namely: George S. Palmer, Thomas C. Kenaston, Clyde O. Anderson, Russell B. Carson, Francis M. Watson, William C. Thomas Jr., Emmett E. Martin and Erasmus B. Hardee.

Last but not least, I wish to thank William C. Roberts for stepping in the gap at my request to fill in for Francis M. Watson who was out because of illness. Dr. Roberts did a magnificent job in a certain investigative matter of Northwest Florida and was instrumental in the great success that was had in the Northwest District Meeting at Tallahassee.

Supplement

The supplement to this report merely deleted the third paragraph of the report as published in the Handbook.

Respectfully submitted,
John D. Milton, *Chairman*

Dr. McEwan: "The report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, presented by Dr. J. Rocher Chappell, Chairman, is approved as presented and I move this report be adopted."

Seconded by Dr. Thomas H. Bates.

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

Your Committee does not have a report to make because the activities of the Committee have been at a standstill since the last meeting of the Florida Medical Association in April, 1953. In fact, your Committee has not met since that time. The drafting of physicians is at a standstill and probably will be until late fall.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Dr. McEwan: "The report of the Committee on Emergency Medical Service presented by Dr. James V. Freeman, Chairman, is approved as published. I move it be adopted."

Seconded by Dr. Homer L. Pearson Jr.

Motion carried.

Report of Committee on Emergency Medical Service

James V. Freeman, *Chairman*

The Committee work this past year has consisted chiefly of consolidation of the pre-existing plan for emergency medical service on a state-wide basis under the guidance of Colonel R. G. Howie, Director of Civil Defense for the State of Florida. Most of this work has of necessity been locally in Jacksonville, inasmuch as Colonel Howie's office is here and your Chairman is available to him. The over-all plan contemplates the local civil defense units at city and county levels, these units being under the direction of local individuals of the respective areas. At the state level the planning comprises chiefly of standardization and unification of the various plans and services so that in the event of any major disaster, trained personnel such as doctors, nurses, etc., can be adequately utilized in their own locality if the need exists, or if there is a catastrophe in other areas, such trained personnel can be shifted to the scene of the disaster. The State Board of Health has a moderate amount of mobile equipment which could be used for disaster purposes. It is the desire of the civil defense director, provided funds are available, to secure more mobile medical emergency equipment to be stationed at strategic points within the state, so that such units together with the personnel can be moved into disaster areas.

Respectfully submitted,
James V. Freeman, *Chairman*

Dr. Herpel: "If I may have the indulgence of this House, I would like to bring up one additional matter. I think we have just time enough before the election of officers. It will require a two-thirds vote in favor of deviating from the rules to present this one matter which should have your attention."

Dr. Milton: "I move that we suspend the rules to present a matter which should have come up at the first meeting of the House of Delegates."

Seconded by Dr. Herz.

Motion carried unanimously.

Dr. Herpel: "At each of the Medical District Meetings last fall, there was presented, on behalf of the Marion County Medical Society, a proposition to establish a Stewart Thompson Memorial Fund to aid medical students at the University of Miami or the medical school in Gainesville. This was presented and much work was done by Dr. Richard C. Cumming, and in principle it was approved at each Medical District meeting.

"I gave this to a committee, but they did not bring in a resolution yesterday. Therefore, I would like to present to you at this time only the fundamental principle for approval, leaving out all details, which I think can be worked out later. It was not my purpose that this memorial fund should have any direct connection with the Florida Medical Association, except a membership connection. I would like to have approval for the following:

1. The Stewart Thompson Memorial Fund is set up to aid medical students of the state of Florida studying in Florida medical schools.
2. The fund is to be made up of voluntary contributions in the interest of medical education in the state in memory of a man who for nearly three decades was vitally concerned with the welfare and progress of the Florida Medical Association.
3. To establish the fund, contributions of any amount from one dollar up may be made through the Florida Medical Association during the year 1954.
4. To perpetuate the fund, each year a member of the Florida Medical Association may contribute one dollar when he pays his state and county dues.
5. The administration of the Stewart Thompson Memorial Fund shall be under the direct control of a committee of one or more men appointed by the President of the Florida Medical Association, representing each of the districts of the Association.
6. This committee shall direct the use of the fund, but shall be advised by the Board of Governors and responsible to the House of Delegates of the Florida Medical Association.

Dr. Turner Z. Cason: "I move that we approve this in principle."

Seconded by Dr. Frazier J. Payton.

Dr. Rowland E. Wood: "I think in setting up this fund there should be some provision made that those be accredited medical schools. The University of Miami, I believe, will be accredited in two more years after they have graduated their first class. It would be unwise to make this fund available to students of a non-accredited school."

Dr. Herpel: "We will leave that to further study of the committee. It is not in position yet to be presented definitely. We are only approving the principle."

Dr. Russell B. Carson: "Shouldn't we first authorize the president to appoint the Committee? I move that the motion be amended that we authorize the president to appoint this committee and that we approve the Memorial Fund in principle."

Seconded by Dr. Wilson T. Sowder.

Amendment carried.

Upon being put to a vote, the motion as amended carried.

Dr. Herpel: "According to the order of business, we shall proceed to the election of officers. These elections will, of course, be by ballot. I would like to appoint as tellers, Dr. Ralph M. Overstreet Jr., Dr. Franklin J. Evans, Dr. Frazier J. Payton and Dr. Thomas C. Kenaston."

Dr. Walter C. Payne Sr. of Escambia was recognized.

Dr. Payne: "Mr. President, Members of the House of Delegates of the Florida Medical Association: Time was not long past when the office of President of the Florida Medical Association was largely an honorary one. Today that is not true. With the economic, social and political changes taking place in our country and throughout the world, the Florida Medical Association today is faced with serious problems. It behooves us to pause and to consider well the one whom we would choose to be our President.

"I have in mind one of our members, who, by reason of his years of experience in the affairs of this Association, by reason of his integrity, of his courage, and of his proven leadership, is eminently qualified to lead us and to direct the affairs of this Association.

"This man was born in Georgia and received his M.D. from Emory in 1923. He chose Florida as the state where he wished to practice and moved to Miami in 1925. Since that time, he has conducted himself in a manner that reflects credit not only to himself, the Dade County Medical Association and the Florida Medical Association, but also on the state of Florida and these United States as well.

"As an indication of his professional qualifications, I would like to name a few of the organizations to which he belongs. He is a Diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Surgeons, the International College of Physicians and Surgeons and the Southeastern Surgical Congress.

"As evidence of the way in which he has served the Dade County Medical Association, he has been vice president and president of that organization as well as having served on the Board of Trustees and as chairman of the Executive Committee.

"The State Association he has served faithfully and well in many positions, among them, Chairman of the Committee on Medical Economics, Chairman of the Sub-Committee to the Board of Governors on Fee Schedules for the last three years; and I am sure all of you know he has done an enormous amount of work and has done an outstanding service to our Association through this committee. During the last year, he has been Chairman of Council. He has served for many years on the Board of Governors.

"I should like to add also that he has been president of the medical staff of the Victoria Hospital of Miami, secretary of the Executive Staff of Jackson Memorial Hospital, and president of the Miami Obstetric and Gynecology Society.

"With all of these duties calling on him for his time and talents, he has given freely to his community. He has been president of the Medical Service Bureau, chairman of the Dade County Medical Division of Civil Defense, chairman of the medical division of the Dade County Chapter, American Red Cross, and has served his community in many more important ways.

"As an evidence of his patriotism and the way he has served his country, during World War II he joined the United States Army as a Captain in 1941 and was released from active duty as a Colonel in 1946.

"It has been my privilege to serve on the Board of Governors for many years with this man and as such, I have had the opportunity to observe him closely. His meeting of the problems and his advice on matters coming before the Board of Governors have won the admiration and respect of all members of the Board. He has one rule by which he measures every problem coming before the Board of Governors, that is, what is good for the Florida Medical Association, what is good for the state of Florida, with never a selfish motive in his actions.

"A few years ago, the Florida Medical Association honored me by allowing me to serve as your president. At that time I resolved to spend the rest of my life showing as best I could my deep appreciation for this honor. So it is today,

in following this resolve, I have the honor, the privilege and the very great pleasure to place in nomination for President-elect of the Florida Medical Association, the name of Dr. John D. Milton."

The Chair recognized Dr. Thomas H. Bates of Columbia.

Dr. Bates: "Mr. President, Members of the House of Delegates: I want to rise to a point of personal privilege. That point is this. When the man has done you the honor to make you his friend and to be your friend, and when he has done you the honor to nominate you to an important position in this organization, that should entitle one to claim the privilege of seconding the nomination of Dr. John D. Milton for President-elect of the Florida Medical Association."

The Chair recognized Dr. N. Worth Gable of Pinellas.

Dr. Gable: "Gentlemen: On behalf of the Pinellas County Medical Association, I would like to second the nomination for my friend, John Milton. You have heard all the nice things said about John. I have known him longer than you have, being a classmate of his for four years in medical school. I could tell you some things about John not printed in the Handbook, but by mutual consent we have deleted those things. On behalf of the Pinellas County Medical Society, I take pleasure in seconding the nomination."

The Chair recognized Dr. Ralph Herz of Monroe.

Dr. Herz: "Mr. Chairman, Fellow Members: When Dr. Payne said that Dr. Milton was born in Georgia, someone said, 'That's held against him.' I don't think you should do that. You also heard about his accomplishments. He is not only a Diplomate, but a diplomat. There was a time in my county when Hippocrates was a legend, ethics was a word in the dictionary, and the sixth amendment to the Constitution of the United States did not exist. I appealed to the Council to look into this situation and Dr. Milton came down to investigate.

"I don't know how he did it, but in due time life became bearable in our county and that condition still exists. He demonstrated his ability as a diplomat and I urge you to cast your ballot for Dr. John Milton."

Dr. Herpel: "Are there any other nominations?"

Dr. Cecil M. Peek: "I move that nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Milton."

Seconded by a chorus of voices.

The Chair called for a rising vote.

The House of Delegates rose in unison.

Dr. Herpel: "John, if your legs are not made of rubber, you may wish to come up here."

Dr. Milton: "Mr. President and Members of the House: I do not have words to express to you my feelings. I assure you that when my year comes round, I will do everything in my power to serve you well.

"I thank you."

The Chair called for nominations for First Vice President.

Dr. Cecil M. Peek of Palm Beach: "I have the privilege of placing in nomination, on behalf of the Palm Beach County Medical Society, the name of one of our members for First Vice President. Our nominee is not from Georgia, he is a native son of Florida. He was born and raised in Key West, graduated from Tulane, took his residency at Touro Infirmary, has 25 years of practice in West Palm Beach.

"I cannot tell you how much the practice of medicine in Palm Beach County revolves about Dr. Johnson. It goes far beyond what is expected of a top flight pathologist. He has established our blood bank and tumor clinic. He is in a position of leadership, and has been for years, in both of our general hospitals. He is at present Chief of Staff of the Good Samaritan Hospital and has been very active in community projects of all sorts. He is a past president of our county medical society and has been for many years a member of this House of Delegates. He has served well and given unstintingly of his time in serving on committees of the Florida Medical Association and is presently a member of Reference Committee No. 2 of this Association.

"If I were to list all of the many offices and all of his contributions and all of his qualifications and all he has done for medicine in Florida, I would keep you here all afternoon, and I promise not to do that. He is a past president of the Florida Society of Pathologists and is the present councilor for Florida of the American Society of Clinical Pathologists.

"Palm Beach County places in nomination for the office of First Vice President the name of Dr. V. Marklin Johnson."

The Chair recognized Dr. Ralph W. Jack of Dade.

Dr. Jack: "Mr. President, Members of the House of Delegates: I am sure that several of you have heard me voice my opinion on previous occasions regarding the choice of vice presidents. I think many organizations have unfortunately at times rather sadly learned the lesson of the need of a good vice president. I think that all of us can even look back through history and remember times when major parties of our government have played politics rather than consider the choice of the vice president because of real qualifications for leadership. For that reason, I think we should not only today, but at all times, very seriously consider the office of first vice president.

"It has been the habit in many organizations to make it purely an honor. It is nice to honor some of our men whom we feel deserve such honors, but we must always consider that that man may have to be our leader and we should pick a man who has shown through the years of experience and work his ability to carry on in that position, and to assume other duties if they should fall to him; and it is my privilege to second the nomination of Dr. V. Marklin Johnson."

The Chair asked if there were any further nominations.

Dr. Thomas C. Kenaston: "I move that nominations be closed and the secretary instructed to cast the ballot for Dr. Johnson."

Seconded by Dr. Ralph Herz.

Motion carried.

The Chair called for nominations for Second Vice President.

Dr. Thomas C. Kenaston of Brevard: "I nominate Dr. Frederick H. Bowen of Duval.

Seconded by Dr. Turner Z. Cason.

Dr. Herbert L. Bryans: "I move that nominations be closed and the secretary be instructed to cast the ballot for Dr. Bowen."

Seconded by Dr. F. Gordon King.

Motion carried.

The Chair called for nominations for Third Vice President.

Dr. Turner Z. Cason of Duval: "I would like to nominate Dr. Rowland E. Wood of Pinellas. He is a young man among us and I think we need a young man."

Dr. H. Phillip Hampton: "I move that nominations be closed and the secretary be instructed to case the ballot for Dr. Wood."

Seconded by Dr. Eugene B. Maxwell.

Motion carried.

Dr. Herpel: "Nominations are now in order for the office of Secretary-Treasurer."

Dr. Jere W. Annis of Polk: "I would like to claim my perennial privilege and pleasure in renominating for the third, and certainly not the last time, Dr. Samuel M. Day."

Dr. H. Phillip Hampton: "I move that nominations be closed."

Seconded by Dr. Joshua C. Dickinson.

The Chair called for a rising vote.

Motion carried unanimously.

The Chair called for nominations for Editor of The Journal.

Dr. Franz H. Stewart of Dade: "I would like to suggest a little quiet time before we consider the nominations for the next officer.

"Among your duties as delegates, we are asking you to assume one more duty, that of making a prophesy. Before you make this prophesy, let's all look back and each ask ourselves a question. Where were you and what were you doing? The year was 1925. Big Bill Tilden was doing beautifully on the courts. Bobby Jones was the golfer. Jack Dempsey was champion. The delegates of the Florida Medical Association elected an Editor of The Journal and at that time they looked back on a long heritage of good work. That was in 1925. What were you doing at the time Shaler Richardson was first elected Editor?

"Since 1925, many changes have come about, not only in sports, but also in our profession, and through this time all the actions of this Association have been reflected in The Journal. There have been many presidents, and certainly, I would not detract from the influence each of these men has had on this Association, but for 30 years, this Journal has been landing on your desk every month. Every month, you must have picked it up and at least glanced through it, and it told you: 'I am a member of this organization and this organization is doing good work for medicine in this state.' Never have you picked up that Journal and found anything which was a cry for radicalism or sectionalism — there was no implication that there were sections in the state.

"The fact that Shaler Richardson has done all that has nothing to do with whether he should be the Editor in the future. What we want now is a man who can carry on this work and I ask you to make a prophesy — who should this be?

"I don't think you will find anyone who can do this more capably than Dr. Shaler Richardson."

Seconded by Dr. Wilson T. Sowder.

Dr. John D. Milton: "I move that nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Shaler Richardson.

Seconded by Dr. H. Phillip Hampton.

The Chair called for a rising vote.

Motion carried unanimously.

Dr. Richardson: "As always, I am deeply grateful to the members of the Association and I esteem it as a great honor to be your Editor. It is always a privilege to work with the Association. The cooperation I get is the thing that makes our Journal worthwhile. Thank you again."

Dr. Herpel: "I will revert to the order of business. We will now have the report of the Board of Past Presidents."

Dr. Homer L. Pearson Jr.: "It seems that everybody is making speeches today. The Board of Past Presidents met at breakfast this morning, on April 28, and it is from this meeting that I shall report. There were several matters discussed. First, the matter of the date for the meeting of the Board of Past Presidents. We are not sure whether it was deliberately set for the last day of the convention, to keep us from bringing anything to the first House of Delegates. Perhaps the powers that be felt that if we have our meeting the last day, we will be unable to create much trouble. We wish to be of help to you if we can and we don't wish to be in the way; but some time or other we may wish to present a proposal or make a resolution. After we meet it is too late to make any new resolutions and everybody wants to go home. We would, therefore, like to request that the Board of Past Presidents be scheduled to meet on Monday instead of Wednesday.

"The next matter discussed was that of prizes given for various activities at the convention. From the beginning it has been customary to solicit these prizes. We do not object to prizes, but we believe the Association should be too big to solicit and ask for prizes. It has been suggested that if the Association cannot afford to buy them, then a small donation, of say $1.00, be charged each participant for the purpose of purchasing these prizes. If any person or company wishes to present a prize, it will be gratefully received."

Dr. Herpel: "I am sure when the meeting of the Board of Past Presidents was set up in the By-Laws, after the First Meeting of the House of Delegates, there was no intention of ham-stringing the activities of this Board and I think there should be incorporated a change in the By-Laws to permit the past presidents meeting before the First House of Delegates. I agree with you completely.

"At this time, I would like to say that we have received cordial greetings from the Florida State Dental Society and we have sent a telegram of congratulations and best wishes.

"I also received a telegram of best wishes from Senator Leroy Collins, much the same as I received from Acting Governor Charley Johns, and I have answered it in the same vein. I have been most diplomatic and most truthful."

"The next order of business is to see that the incoming president has sufficient leg support to get up here. Will Dr. Edward Jelks and Dr. Walter C. Jones please escort the incoming president to the Chair?"

Dr. Jones: "Dr. Jelks is not in the room at the moment."

Dr. Herpel: "Dr. Orr, will you serve and escort the incoming president to the Chair?"

Dr. Duncan T. McEwan, President-elect, was escorted to the rostrum.

Dr. Herpel: "It is now my privilege to present to the incoming President his official gavel which is engraved with his name and term of office. I know that he will wield this gavel with discretion during the coming year."

Dr. McEwan: "Thank you, Fred.

"Members of the House of Delegates, Woman's Auxiliary and Guests: I am very happy to be here as your President. It is surely a great honor to be President of this Association. I realize how great an honor when I come to these meetings and meet the men who are past presidents. I have always felt that they are great men and that they have given invaluable service.

"I first became interested in this Association when I was practicing with Dr. Gaston Edwards

and with my uncle, Dr. John S. McEwan. Jack, are you here today? Stand up — I want to pay homage to my uncle."

Dr. John S. McEwan rose and the House applauded.

Dr. Duncan T. McEwan: "He did a great deal for this Association as President and he nursed me along in the Association. I am grateful to him today as your incoming President.

"We not only have a great Board of Past Presidents, but in making committee appointments, I find we have so many good men that it has been difficult to pick from among you, and I think we have the foremost society in the nation.

"Fred, the administration you have given us has been outstanding because of great force of character, high ideals and administrative ability. It is my great pleasure today, as my first official act, to present to you the Past President's Button.

"With this goes a certificate of honor, in appreciation of all that you have done."

Dr. Herpel: "I am supposed to be crying at this point, but I am not. I have seen a number of past presidents break down at this point, but frankly, I can't break down; I have had such wonderful support from everyone in the Association."

Dr. McEwan: "I want to express my appreciation to everyone who had anything to do with making this an outstanding meeting.

"Is there any new business to be brought before this session?

"Are there any announcements?

"I wish to announce that the Board of Governors will meet in room 546 immediately following this meeting. Dr. John D. Milton will, of course, meet with us as President-elect; and Dr. Edward Jelks, who by our action, serves on the Board of Governors as our Liaison on Public Relations and Dr. Russell B. Carson.

"A motion to adjourn is in order."

There being no further business, on motion from the floor, duly seconded and carried, the House of Delegates adjourned, sine die, at 12:40 p.m.

ARE YOU MOVING?

Please send the following to: Florida Medical Association, P.O. Box 1018, Jacksonville, Fla.

Name .....
(Please print)

Old Address:

Street .....

City & Zone .....

State .....

New Address:

Street .....

City & Zone .....

State .....

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:45 a.m., Monday, April 26, in the Mardi Gras Room with Dr. Jere W. Annis of Lakeland presiding. The following papers were read and discussed:

"Extensive Surgery and Repeated Surgery for Malignant Diseases," Samuel M. Day, Jacksonville.

"Recent Trends in Medical Education," George A. Bennett, Philadelphia.

"The Treatment of Inoperable Prostatic Carcinoma with Au 198," Louis M. Orr, James L. Campbell Jr. and Miles W. Thomley, Orlando. Presented by Dr. Orr.

"Rheumatic Fever in a Subtropical Climate," Milton S. Saslaw, Miami.

"The Conquest of Pain," C. MacKenzie Brown, Tampa.

Second Scientific Assembly

The second Scientific Assembly convened at 2:00 p.m., Monday, April 26, in the Mardi Gras Room with Dr. Annis presiding. The following papers were read and discussed:

"Cosmetic Surgery," George W. Robertson III, Miami.

"Functioning Ovarian Tumors," Malcolm B. Dockerty, Rochester, Minn.

"Pelvic Operations — the Preferred Vaginal Approach," W. L. Thomas, Durham, N. C.

After recess, the Assembly reconvened with Dr. Sidney Davidson of Lake Worth presiding.

"Evaluation of Cardiovascular Surgery," DeWitt C. Daughtry and John G. Chesney, Miami. Presented by Dr. Daughtry.

"A Statistical Analysis of 181 Consecutive Cases of Bronchogenic Carcinoma," J. Brooks Brown, Jacksonville.

"Solitary Discrete Pulmonary Densities," George H. McSwain, Daytona Beach.

Third Scientific Assembly

The third Scientific Assembly convened at 2:30 p.m., Tuesday, April 27, in the Mardi Gras Room with Dr. Davidson presiding.

First on the program was a symposium on "The Differential Diagnosis of Jaundice," moderator, Eric E. Wollaeger, Mayo Clinic, Rochester, Minn. The following papers were presented and discussed as part of the symposium:

"The Role of the Clinical History and Physical Examination," Eric E. Wollaeger, Rochester, Minn.

"The Role of Liver Function Tests and General Laboratory Findings," James L. Borland, Jacksonville.

"The Role of Liver Biopsy," Theodore C. Keller, Miami.

After recess, the following papers were read and discussed:

"Vagotomy and Gastroenterostomy for Duodenal Ulcer," Chester C. Guy, Chicago.

"Management of Upper Gastrointestinal Hemorrhage," John M. Rumball, Coral Gables.

Fourth Scientific Assembly

The fourth Scientific Assembly convened at 9:00 a.m., Wednesday, April 28, in the Mardi Gras Room with Dr. Annis presiding. The following papers were read and discussed:

"Epilepsy," William H. McCullagh, Jacksonville.

"Muscular Dystrophy in South Florida," John E. Burch, Gaetano T. Samartino and William Pollen, Miami. Presented by Dr. Burch.

REGISTRATION

The registration for the Eightieth Annual Meeting at Hollywood surpassed that of any previous convention of the Association. The total number registered was 1,827. The registrants included 852 members of the Association, 230 visiting physicians, 38 other guests, 438 members and guests of the Woman's Auxiliary, 14 scientific exhibitors, and 255 representatives of exhibiting firms. There were 25 other states, Alaska, Cuba and Puerto Rico represented.

Registration List

Officers

Frederick K. Herpel, President ..... W. Palm Beach
Duncan T. McEwan, President-elect ..... Orlando
Thomas H. Bates, 1st Vice President ..... Lake City
Russell B. Carson, 2nd Vice President ..... Fort Lauderdale
Thomas C. Kenaston, 3rd Vice President ..... Cocoa
Samuel M. Day, Sec'y-Treasurer ..... Jacksonville
Shaler Richardson, Editor ..... Jacksonville
Ernest R. Gibson, Act. Managing Director ..... Jacksonville

Members

APALACHICOLA: Photis J. Nichols, Warren T. Weathington. APOPKA: Thomas E. McBride. ARCADIA: F. Erwin Daves, Charles H. Kirkpatrick, Frank J. Liddy, Gordon H. McSwain. AVON PARK: Hubert W. Coleman, Donald C. Hartwell. BELLE GLADE: Wilbert O. Norville, (Col.). BLOUNTSTOWN: Grayson C. Snyder. BRADENTON: Alva J. Floyd, Joseph B. Ganey, Harvey C. Pauley Jr., Millard P. Quillian, Henry E. Rasmussen-Taxdal, Sidney Smith, William D. Sugg. BRANFORD: Edward G. Haskell Jr. BROOKSVILLE: S. Carnes Harvard. BUNNELL: John M. Canakaris.

CHATTAHOOCHEE: William D. Rogers. CLEARWATER: Everett M. Harrison, Francis C. Hoare, James B. Leonard, George H. Schoetker. COCOA: Charles E. Russell. CORAL GABLES: A. Daniel Amerise, Gunnard J. Antell, Ira K. Brandt, E. Hampton Bryson, Charles R. Burbacher, Henry H. Caffee, Philip J. Chastain, Jack Q. Cleveland, Franklin J. Evans, Glenn H. Heller, Edward E. Hodsdon, Jim S. Jewett, Robert P. Keiser, Warren Lindau, Albert M. McCallen, C. Howard McDevitt Jr., Joseph R. Morrow, R. Sam Mosley, Frederick P. Poppe, Warren W. Quillian, T. D. Sandberg, Harold M. Silberman, William P. Smith, Merrick D. Thomas Jr., Rollin D. Thompson, Martiele Turner, Wm. L. Wagener Jr., Arthur H. Weiland, Hillard W. Willis, Bernard Yesner. CRYSTAL RIVER: William B. Moon.

DADE CITY: W. Wardlaw Jones. DANIA: Fred E. Brammer. DAYTONA BEACH: George P. Beach, Charles A. Brown, John J. Cheleden, James W. Clower Jr., C. Robert DeArmas, Peter A. Drohomer, Joseph C. Flynn, David W. Goddard, Herbert A. King, George H. McSwain, Joel Mendelson, James D. Moffett Jr., Howard W. Reed, Joseph H. Rutter. DeFUNIAK SPRINGS: William D. Cawthon. DeLAND: Robert O. Burry, Matthew A. Moroz. DELRAY BEACH: Graham W. King Jr., James R. Nieder. DUNEDIN: James C. Fleming, John A. Mease Jr., James H. Miller Jr., Maurice E. Ross, James F. Spindler.

EUSTIS: Raymond A. Debo, C. McK. Tyre. EVERGLADES: Edward J. Eckel. FERNANDINA BEACH: Cecil B. Brewton. FORT LAUDERDALE: Curtis D. Benton Jr., Miles J. Bielek, Julius F. Boettner, Oliver C. Brown, Mark Butler, Milton N. Camp, Forest W. Cox, Alfred E. Cronkite, Burns A. Dobbins Jr., Frederick J. Driscoll, Robert L. Elliston, Roland F. Fisher, Richard L. Foster, Donald H. Gahagen, Walter J. Glenn Jr., Francis Haberman, George Hamerick Jr., Rudolph W. Heath, Anne L. Hendricks, Garland M. Johnson, William H. Kirkley, M. Austin Lovejoy, Lloyd U. Lumpkin, Thomas L. McKee, Richard A. Mills, Robert U. Moersch, Richard D. Owen, Henry J. Peavy Sr., William K. Peck, Claus A. Peterson, Francis D. Pierce, Raymond M. Price, George M. Rhodes, Thomas L. Roberts, Leigh F. Robinson, Charles F. Seymour, Paul G. Shell, Vincent V. Smith, Curtis H. Sory, Robert G. Talley, Alva R. Taylor, Willard M. Taylor, Charles L. Wadsworth, W. Dotson Wells. FORT MEADE: Taylor D. Bailey. FORT MYERS: Fred D. Bartleson, Ernest Bostelman, Joseph D. Brown, A. Louis Girardin Jr., Angus D. Grace, William H. Grace, H. Quillian Jones, Joseph L. Selden Jr., John S. Stewart, Baker Whisnant. FORT PIERCE: Hugh B. Goodwin Jr., John T. McDermid, Adrian M. Sample, Richard F. Sinnott, Lester L. Whiddon.

GAINESVILLE: Henry J. Babers Jr., F. Emory Bell, Henry S. Blank, J. Maxey Dell Sr., J. Maxey Dell Jr., Marvin L. Kokomoor, Albert G. Love IV, Cecil E. Love, James M. McClamroch, John E. Maines Jr., George H. Putnam, William C. Thomas Sr., I. Irving Weintraub. GROVELAND: John D. Bloom. GULFPORT: James M. Neill. HALLANDALE: Maxwell M. Hartman. HAVANA: James W. Sapp. HIALEAH: Leon S. Eisenman, Elizabeth K. Lovejoy, Albert W. McCorkle. HOLLYWOOD: Thomas S. Adams, Dale T. Anstine, Alexander H. Bluestone, Andre S. Capi, Manuel G. Carmona, Gordon B. Carver, Jerome J. Coffey, Robert H. Farringer, Bertram J. Frankel, Anthony C. Galluccio, Robert R. Harriss, Royle B. Klinkenberg, Elbert McLaury, Charlotte E. Mason, John H. Mickley, Bernard Milloff, Louis J. Novak, Robert J. Patterson, Jacob A. Rosof, Bernard B. Seltzer, Ernest E. Serrano, Randall W. Snow, George P. Sorvas, Samuel Tilles, S. Elliott Wilson, Norman N. Wrubel. HOMESTEAD: Joseph H. Shain. HOWEY-IN-THE-HILLS: Fred A. Vincenti. INVERNESS: Gail M. Osterhout.

JACKSONVILLE: Jackson L. Allgood Jr., S. James Beale, John B. Black, James L. Borland, Frederick H. Bowen, Charles W. Boyd, J. Brooks Brown, Joseph Canipelli, Cornelia M. Carithers, Hugh A. Carithers, Turner Z. Cason, George A. Dame, Sam W. Denham, Joel Fleet, James V. Freeman, Lawrence E. Geeslin, John M. Gorman, A. Judson Graves, Karl B. Hanson, Grace C. Hardy, Charles F. Henley, Cecil M. Hogan, Victor A. Hughes, Edward Jelks, Crowell W. Johnston, Marvin H. Johnston, Millard F. Jones, Raymond R. Killinger, F. Gordon King, Raymond H. King, W. Jerome Knauer Sr., J. Ellis Lanier, Camillus S. L'Engle, Louie Limbaugh, Thomas H. Lipscomb, John F. Lovejoy, Joseph J. Lowenthal, James G. Lyerly, Marvin V. McClow, William H. McCullagh, Robert B. McIver, Milton C. Maloney, Carl C. Mendoza, John H. Mitchell, Bernard L. N. Morgan, Kenneth A. Morris, Seymour Morse, Thad Moseley, Nelson A. Murray, Jerome H. Newman, Robert H. Nickau, G. Frederick Oetjen, Lorenzo L. Parks, Leo B. Provinsky, George I. Raybin, Ferdinand Richards, Wade S. Rizk, Clarence D. Rollins, Joseph H. St. John, Richard G. Skinner Jr., Wilson T. Sowder, Sidney Stillman, Wilbur C. Sumner, G. Dekle Taylor, J. Champneys Taylor, Robert Y. H. Thomas, Richard P. Thompson, Daniel R. Usdin, William A. Van Nortwick, Frederick J. Waas, Leo M. Wachtel Jr., Edward C. Watt, Albert H. Wilkinson, Ashbel C. Williams, J. Frank Wilson, Jonathan H. Wood. JACKSONVILLE BEACH: Charles F. McKay. KEY WEST: Ralph Herz, Herman K. Moore, Allen S. Shepard.

KISSIMMEE: John O. Rao, Eugene R. Speirs. LAKE CITY: Laurie J. Arnold Jr., Robert B. Harkness, Louis G. Landrum, Robert M. Sasso. LAKELAND: Clarence L. Anderson, Jere W. Annis, James R. Boulware Jr., Samuel J. Clark, John E. Daughtrey, Fred I. Dorman Jr., Marion W. Hester, William A. Hodges Jr., T. Hugh Roberts, James T. Shelden, Wylie L. Tillis, Edgar Watson,

John W. Williams. LAKE WALES: Edward C. Burns Jr., Willard E. Manry Jr. LAKE WORTH: Grady H. Brantley, Sidney Davidson, A. Scott Turk, Edward W. Wood. LEESBURG: Arthur P. Buchanan, Marion B. O'Kelley. LIVE OAK: Irby H. Black. MADISON: Harry A. Nevel. MARIANNA: James T. Cook Jr., Courtland D. Whitaker. MELBOURNE: Oswald A. Holzer, Theodore J. Kaminski, Luther T. Pennington Jr., Paul L. Summers.

MIAMI: Lawrence Adler, Isadore H. Agos, Julius Alexander, Lassar Alexander, Ralph F. Allen, James L. Anderson, William G. Aten Jr., Harold P. Auslander, George C. Austin, Hubert A. Barge, William J. Barge, Ernest R. Barnett, Jack W. Barrett, Harry E. Beller, Morris H. Blau, Andrew G. Brown, Earlsworth C. Brunner, John E. Burch, Reuben N. Burch Jr., Bruce D. Carroll, Gerard F. Carter, Chester Cassel, Turner E. Cato, Silas E. Chambers, John G. Chesney, Reuben B. Chrisman Jr., Francis N. Cooke, Maurice P. Cooper, Milton M. Coplan, Vincent P. Corso, Joseph H. Crawley, Edward W. Cullipher, DeWitt C. Daughtry, David Davidson, Carl H. Davis, Robert F. Dickey, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Carl E. Dunaway, John G. DuPuis, Herbert Eichert, Lee W. Elgin, Wm. H. Ellis, Raymond L. Evans, Frederick E. Farrer, Marvin G. Flannery, Richard M. Fleming, M. Jay Flipse, Roger J. Forastiere, Forrest H. Foreman, Hollis F. Garrard, George Gittelson, Francis W. Glenn, J. Raymond Graves, Howard H. Groskloss, Daniel O. Hammond, Henry C. Hardin Jr., Robert M. Harris, W. Tracy Haverfield, Ella M. Hediger, Francisco A. Hernandez, John R. Hilsenbeck, Claude D. Holmes Jr., James W. Holmes, William M. Howdon, R. Spencer Howell, William C. Hutchison, Ralph W. Jack, Truxton L. Jackson, Joseph T. Jana Jr., Paul S. Jarrett, Valentine E. Jenkins, Walter C. Jones, Theodore C. Keller, Ralph E. Kirsch, David Kirsh, Erna K. Klass, Morris E. Kuckku, William T. Lanier, Matthew A. Larkin, George W. Lawson, Frederick LeDrew, Robert M. Lee, Simon M. Lipton, George Lister, Wm. D. Lithgow, A. Buist Litterer, Joseph Lomax, Manuel C. Lores, Joseph H. Lucinian, John J. McAndrew, Jack A. McKenzie, Wm. W. McKibben, Norman W. McLeod Jr., Robert A. McNaughton, Martin P. Mahrer, Plumer J. Manson, Donald F. Marion, Isidore Marx, John H. Mason, Lawrence R. Medoff, Perry D. Melvin, Claude G. Mentzer, Hyman Merlin, Robert F. Mikell, John D. Milton, Leon H. Mims Jr., S. Robert Nash, Leo L. Nastasi, Elwin G. Neal, Wesley S. Nock, Benjamin G. Oren, Samuel W. Page Jr., Bascom H. Palmer, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson Jr., Nelson T. Pearson, Max Pepper, Kenneth Phillips, Roland F. Phillips, Robert C. Piper, Benjamin G. Pollock, James H. Putman, Gerard Raap, Jack O. W. Rash, Homer A. Reese, Maurice Rich, John R. Richardson, Samuel J. Roberts, George W. Robertson III, Reuben Rochkind, Hunter B. Rogers, Charles Rosenfeld, Manning J. Rosnick, Ruth W. Rumsey, Lyle W. Russell, Walter W. Sackett Jr., Ralph S. Sappenfield, Milton S. Saslaw, Chaffee A. Scarborough, Oden A. Schaeffer, George F. Schmitt Jr., Manuel A. Schofman, John M. Schultz, John T. Smedley, Donald W. Smith, John W. Snyder, Robert T. Spicer, Donald G. Stannus, William Steinman, Franz H. Stewart, Joseph S. Stewart, Richard F. Stover, William M. Straight, Richard E. Strain, Harry Tarr, Kelly C. Thomas, Isaac N. Weinkle, Lynn W. Whelchel, William Wickman, Edward H. Williams, George Williams Jr., John E. Williams, Arthur W. Wood Jr., Frank M. Woods, Leo S. Wool, Corren P. Youmans, Casimer A. Zarzecki, Leo A. Zuckerman.

MIAMI BEACH: Mortimer D. Abrashkin, Seymour L. Alterman, Theodore M. Berman, Herman Boughton, Judd R. Breakstone, Rudolph E. Drosd, Maurice I. Edelman, Howard A. Engle, David W. Exley, I. Leo Fishbein, Elias Freidus, Milton S. Goldman, Solomon B. Goldman, Max Gratz, Robert J. Grayson, Irvin M. Greene, Walter T. Hotchkiss, Emil M. Isberg, Lewis L. Julien, Saul H. Kaplan, Harold S. Kaufman, Bernard S. Kleinman, Mathew W. Kobak, Maurice Kovnat, George N. Leonard, Alfred G. Levin, Nathaniel M. Levin, Alexander Libow, Charles Lippow, Meyer B. Marks, Cayetano Panettiere, Jean J. Perdue, Joseph B. Pomerance, Robert J. Poppiti, John A. Renwick, Julian A. Rickles, Maurice J. Rose, Jack A. Rudolph, Maxwell M. Sayet, Charles A. Schwarz, Sol Selevan, Benjamin L. Steinberg, Efton J. Thomas, Rene A. Torrado, M. P. Travers, Harrison A. Walker, Leonard L. Weil, D. Ward White, Maurice Zimmerman, Nelson Zivitz.

MIAMI SHORES: Jesse C. McMillan. MIAMI SPRINGS: Estella G. Norman, Clyde T. Thompson, Dale S. Wilson. MOUNT DORA: J. Basil Hall, Alexander E. Morse Jr. MULBERRY: John A. Ray. NAPLES: Ethel H. Trygstad, Reidar Trygstad. NEW PORT RICHEY: Frank Y. Robson. NEW SMYRNA BEACH: Lee H. Darby. NORTH MIAMI: Mario V. Scandiffio, Ludwig M. Ungaro, Charlotte K. Wilkins. OCALA: William H. Anderson Jr., Richard C. Cumming, Henry L. Harrell, John P. Moore, Eugene G. Peek Jr.

ORLANDO: Clarence Bernstein, Frank C. Bone, Thomas C. Butt, Benjamin M. Cole, Chas. J. Collins, Norman F. Coulter, Russell L. Counts, Francis M. Coy, Horace A. Day, George W. Edwards II, L. Paul Foster, Truett H. Frazier, Benjamin Glaser, Frank D. Gray, Maurice C. Guest, G. Tayloe Gwathmey, David Y. Hicks Jr., Edgar E. Hitchcock, J. Cornall Howarth, Joseph L. Hundley, Eldridge W. Johnson, Solomon D. Klotz, Newton C. McCollough, John S. McEwan, John D. McKey, Carl S. McLemore, James A. McLeod, Charlotte C. Maguire, Meredith Mallory, John G. Marsh, J. William Martin, Fred Mathers, Alexander P. Maybarduk, Royston Miller, William S. Mitchell, Robert G. Neill, Louis M. Orr, Frank M. Parish, Roger E. Phillips, Louis E. Pohlman, Frank J. Pyle, William P. Rice, Don C. Robertson, Jacob R. Rozier, Jack F. Schaber, Geo. P. Schanck Jr., (Col.), Adelbert F. Schirmer, Lowell S. Selling, Joseph G. Seltzer, Charles R. Sias, Philip F. Simensky, Freeman D. Stanford, Joseph L. Stecher, Robert L. Stephens, Ernest J. Stevens, Alfred S. Stevenson, W. Dean Steward, Robert L. Tolle, A. Fred Turner Jr., Breckenridge W. Wing, Robert W. Young, Robert E. Zellner.

PAHOKEE: Chas. E. Creel, Ernest C. Johnson Jr. PALATKA: Lawrence G. Hebel. PALM BEACH: George M. Dawson, Oscar L. Kelley, David A. Newman, Bailey B. Sory Jr., Joseph R. West. PANAMA CITY: Jack Corbitt, William F. Humphreys Jr., James A. Poyner, William C. Roberts, Harold E. Wager. PENSACOLA: Paul F. Baranco, Herbert L. Bryans, Arthur J. Butt, Gustav N. Click, William P. Hixon, Sidney G. Kennedy Jr., Mozart A. Lischkoff, John J. McGuire, George W. Morse, William T. Patton, Walter C. Payne Sr., Frank E. Tugwell, William L. Williams, Dale E. York. PERRY: Ralph J. Greene. PLANT CITY: William G. Meriwether. POMPANO BEACH: Wilks O. Hiatt Jr., George S. McClellan. PORT ST. JOE: Albert L. Ward. QUINCY: Julius C. Davis. RAIFORD: Mark E. Adams. RIVIERA BEACH: Frank M. Hewson Jr.

ST. AUGUSTINE: Reddin Britt, S. Raymond Cafaro, Charles C. Grace, George C. Hopkins, Vernon A. Lockwood, Herbert E. White. ST. PETERSBURG: Arnold S. Anderson, Clyde O. Anderson, George H. Anderson, Grover W. Austin, Walter H. Bailey, Kenneth A. Baker, Carl Z. Berry, Curtis W. Bowman, John P. Boyle, Edward L. Cole Jr., John H. Cordes Jr., Harry R. Cushman, William M. Davis, Luverne H. Domeier, Woodrow B. Estes, Ira C. Evans, Leonard Freed, N. Worth Gable, Sidney Grau, Dean W. Hart, Paul S. Herr, George F. Hieber, Robert M. Kilmark, Frederick C. Knight, Francis H. Langley, Whitman C. McConnell, Norval M. Marr, Alvin L. Mills, Orville N. Nelson, Edwin C. Northup, Joseph W. Pilkington, Richard Reeser Jr., Franklin W. Roush Jr., John P. Rowell, Benjamin H. Sullivan, Abbott Y. Wilcox Jr., Rowland E. Wood.

SANFORD: Terry Bird, J. Clifford Boyce. SARASOTA: John M. Butcher, Michael A. DiCosola, Lloyd J. Duest, Thomas V. Finch, Ernest M. Grochowski, J. Edward Harris, Andrew J. Jesacher, Edmund P. Kelley,

Harold T. Lawler, Eugene D. Liddy Jr., Stanley T. Martin, Henry G. Morton, Robert O. Pitts, Hugh G. Reaves, William A. Shannon, Melvin M. Simmons, Thomas C. Stansbury Jr., Henry J. Vomacka, Millard B. White, Reaves A. Wilson.

SEBRING: Leldon W. Martin, Stanley K. Wallace. SOUTH MIAMI: Henry H. Bryant III, Robert V. Edwards, Donald E. Fortner, James H. Mendel Jr. STARKE: Thomas G. Ritch. STUART: John M. Gunsolus. SURFSIDE: C. J. Golinvaux. TALLAHASSEE: Edson J. Andrews, Paul J. Coughlin, T. Bert Fletcher Jr., Francis T. Holland, Charles F. James Jr., Clarence W. Ketchum, George S. Palmer, Henry L. Smith Jr.

TAMPA: Samuel H. Adams, Chas. W. Bartlett, William C. Blake, Ernest R. Bourkard, C. MacKenzie Brown, Leffie M. Carlton Jr., Harold Carron, Frank V. Chappell, M. Austin Chardkoff, C. Frank Chunn, Herschel G. Cole, Lewis T. Corum, Eugene F. Costantino, Oliver F. Deen Jr., Joshua C. Dickinson, Thomas M. Edwards, Irving M. Essrig, J. Brown Farrior, Gaetano C. Ferrante, Sherman B. Forbes, Elsie M. Gilbert, Eugene S. Gilmer, Chas. Mc. Gray, H. Phillip Hampton, Samuel G. Hibbs, James B. Hodge Jr., A.M.C. Jobson, Wm. J. Lancaster, Frank H. Lindeman Jr., Frank T. Linz, Blackburn W. Lowry, Paul J. McCloskey, Myron L. McEachern, Thomas E. McKell, Douglas D. Martin, Alfonso F. Massaro, Eugene B. Maxwell, Joseph A. Minardi, David R. Murphey Jr., William M. Myers, Robert G. Nelson, Thomas F. Nelson, Julien C. Pate Sr., Anthony P. Perzia, Curtis G. Rorebeck, William M. Rowlett, Joseph J. Ruskin, James M. San, Hawley H. Seiler, Alvord L. Stone, Harold Sutker, Joseph W. Taylor Sr., Joseph W. Taylor Jr., Joseph N. Torretta, Arthur J. Wallace, Augustine S. Weekley, Walter H. Wellborn Jr., J. Maxwell Williams Jr., Frances C. Wilson, Wesley W. Wilson, Robert W. Withers. TAVARES: James R. Hanson.

VENICE: Samuel E. Kaplan. VERO BEACH: Vernon L. Fromang, John P. Gifford.

WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, Horace D. Atkinson, John M. Baber, R. Henry Baldwin, Harry E. Bierley, Edwin W. Brown, Clarence L. Brumback, Victor Clarholm, Thomas E. Daly, Joseph J. Daversa, C. Jennings Derrick, Gerald M. DeWoody, Hugh Dortch Jr., John H. Dyett, (Col.), William H. Gardner, W. Wellington George, Richard S. Gill, Guy W. Heath, Alfred F. Henderson, Richard M. Irwin, V. Marklin Johnson, Oliver L. Jones, Edgar A. P. Kellerman, Lawrence R. Leviton, R. Gaylord Lewis, W. Ambrose McGee, David W. Martin, Lloyd J. Netto, Walter R. Newbern, Theodore Norley, Ralph M. Overstreet Jr., Cecil M. Peek, Atwell B. Pride, (Col.), Raymond S. Roy, William Y. Sayad, Ivan C. Schmidt, James R. Sory, Younger A. Staton, Edgar W. Stephens Jr., Laurie R. Teasdale, Wm. E. Van Landingham.

WINTER HAVEN: Ivan W. Gessler, Robert J. Jahn, Henry F. Keiber. WINTER PARK: Walter B. Johnston, Albert C. Kirk Sr., William L. Musser.

Visiting Doctors

ARCADIA: August C. Herman. BOYNTON BEACH: Robert E. Raborn. BUSHNELL: Leo L. Burger. CORAL GABLES: Egil Amundsen, George L. Baum, T. H. Boyd, John A. Broward, Bernard K. Guerin, Herbert S. Kaiser, Chas. A. Monnin Jr., Jack Reiss, John M. Rumball, Myron Saline, Burnett Schaff, S. D. Snow, Jay N. Wemple, Warren Zundell. DUNEDIN: Malcolm MacKenzie.

FORT LAUDERDALE: Louis L. Amato, James W. Dickey Jr., Robert S. Faircloth, Simon I. Kemp, Lees M. Schadel Jr., Henry R. Steadman. FORT PIERCE: John D. Browning, C. A. Pigford. GAINESVILLE: George T. Harrell. GULFPORT: Richard M. Free. HIALEAH: Oliver D. Anderson, Karen Howard. HOLLYWOOD: Milton S. Mongek, Harry M. Permesly, Donald L. Peterson, William J. Ramel, Herbert J. Simon. JACKSONVILLE: Frank D. Burns, Thomas B. Christian, Charles H. Gilliland, Albert H. Wilkinson Jr. KISSIMMEE: Kingsley Bishop. LAKE ALFRED: Edgar B. Hodge. LAKELAND: Joseph R. Galluccio. LAKE WORTH: Leonard W. Appleby, Arthur T. Rask, H. John Richmond. LANTANA: Anthony V. Camera, John E. Costello, Verne A. Dodd.

MIAMI: Bernard Abel, J. Ernest Ayre, Thomas J. Baker, John C. Branham, David N. Burns, M. M. Dick, Morris Dressler, Claude G. Eccles, Jacques Freeman, Michael M. Gilbert, Martin G. Gould, Thomas S. Gowin, M. N. Greenhouse, Arnold Grier, Thos. S. Griggs, Stuart L. Haas, Bernard Halperin, P. E. Howard, Marshall Hyde, John D. Jackson, Norman Jaffe, Max M. Kulvin, Hilbert A. P. Leininger, Richard S. Lewis, Taylor Lewis, Mariano P. Martinez, Julius D. Menta, Douglas C. Morris, Irvin S. Morse, Harry C. Nelson Jr., Jacinto L. Nobo, Philip Oransky, Arturo C. Ortiz, J. Padilla, C. G. Patten, Walter H. Pinkus, Gerald B. Reams, Albert Reinherz, Billy P. Rentz, Gaetano T. Samartino, Harold W. Snodgrass, Calvin N. Steussy, William B. Welch, William J. Winter Jr., John L. J. Wolford, Alfonso Zurek.

MIAMI BEACH: Maryland B. Byrne, H. Lack, Daniel L. Stone, A. J. Strikol, Harold D. Van Schaick, Marvin L. Weil, William S. Weinkle, Daniel H. Zimmerman. MULBERRY: Leonard L. Bratcher. NORTH MIAMI: Ralph J. Haws, Edward J. Lauth Jr. NORTH MIAMI BEACH: John A. Heffernan. ORLANDO: Laurence A. Bilotta, Alda G. Duckworth, William R. Willis. PENSACOLA: Herman S. Shapiro. POMPANO BEACH: Francis J. McNally, James A. Pickering. ST. PETERSBURG: Milton B. Cole, A. E. Gehrke, Chester F. Johnson, V. R. Payne, Hans A. Whalen. SOUTH MIAMI: Franklin H. Cox. SURFSIDE: Samuel A. Gunn. TAMPA: Robert J. Davis.

WEST PALM BEACH: Margaret Bashford, William H. Everts, V. E. Haynes, Philip O. Lichtblau, Glenn H. Morton, David H. Rowe, John D. Stevenson, Robert J. Trope.

ALABAMA-BRENT: W. J. Owings. DOTHAN: John T. Ellis. CALIFORNIA-ALHAMBRA: Royal G. Tucker. SAN MATEO: Henry C. Traska. COLORADO-DENVER: Thomas L. Howard. CONNECTICUT-HARTFORD: M. A. Crispin, Norman Mann. WILLIMANTIC: Newton Arnold, William S. Maurer. DELAWARE-MILFORD: Kaden Tierney. WASHINGTON D. C.: Philip J. Lowenthal, Maurice Protas, Frank E. Wilson, Joseph R. Young. GEORGIA-ATLANTA: Ottis E. Hanes, John R. Lewis Jr., J. Gordon McAllister. FOLKSTON: Joseph M. Jackson Jr. LAGRANGE: James W. Chambers.

ILLINOIS-CENTRALIA: Harry E. Ryan. CHAMPAIGN: J. Allen Baker. CHICAGO: Charles Fields, Chester C. Guy, George A. Karp, H. P. Saunders, Elmer E. Swanson. INDIANA-BEDFORD: R. B. Smallwood. FORT WAYNE: Emory D. Hamilton, Richard B. Smith. HAMMOND: A. C. Remich. MUNCIE: Charles R. Alvey. SOUTH BEND: John W. Karn. TERRE HAUTE: John E. Miklozek. KENTUCKY-MURRAY: Conrad H. Jones, C. C. Lowry. RUSSELLVILLE: C. U. Dodson. LOUISIANA-NEW ORLEANS: Stanley Cohen, Francis E. LeJeune. SHREVEPORT: Joseph S. Shavin. MASSACHUSETTS-CHELSEA: Stewart A. Wilber. MICHIGAN-ADRIAN: Carl A. Benz, Charles H. Heffron. DEARBORN: J. W. Pichette. DETROIT: Benjamin Brand, Eugene A. Osius, Nelson J. Young. FLINT: Sidney R. Michael. LANSING: William C. Behen. MOUNT CLEMENS: J. N. Scher. MINNESOTA-MINNEAPOLIS: Frank J. Hill. ROCHESTER: Malcolm B. Dockerty, M. C. Petersen, Eric E. Wollaeger. ST. PAUL: R. O. Leavenworth. MISSOURI-JOPLIN: Irwin T. Craig. KANSAS CITY: J. Sidney Rubin.

NEW JERSEY-PLAINFIELD: Grace M. Robertson. NEW YORK-BROOKLYN: Edward H. Nidish, Harvey Wiener. HOOSICK FALLS: Harold G. Stacy. NEW YORK: Joseph Harris, George T. Pack, Julius L. Rogoff, Frederick H. Theodore. ROCHESTER: Herbert A. Molser, Philip M. Winslow. ROSLYN HEIGHTS: A. S. Goss. RYE: Richard B. Hadley, David W. Wilson. NORTH CAROLINA - ASHEVILLE: R. C. Nailling. CANTON: Hugh A. Matthews. DURHAM: W. C. Davison, W. L. Thomas. WHITEVILLE: W. E. Miller.

OHIO-BRADFORD: Emory R. Irvin. CINCINNATI: Edward O. Hoffman, A. Ashley Weech. CLEVELAND: June Dvorak. CRESTLINE: Robert A. Borden. DAYTON: Robert E. Boswell, Lawrence J. Lohr, Paul J. Shank. LYNCHBURG: John G. Anderson. MIDDLETOWN: Robert M. Wilson. YOUNGSTOWN: Thomas A. Ferguson.

PENNSYLVANIA-HAVERFORD:: James I. Hykes. PHILADELPHIA: George A. Bennett, William N. Parkinson, Franklin S. Rutberg. PITTSBURGH: Geo. E. Crum, Harvey E. Thorpe. TARENTUM: George F. Edmonston. SOUTH CAROLINA-GREENVILLE: Raymond C. Ramage. TENNESSEE-COVINGTON: Sterling Ruffin. KNOXVILLE: Jarrell Penn. TEXAS-HOUSTON: Alvis E. Greer. VIRGINIA-ROANOKE: Julien H. Meyer. WISCONSIN-MILWAUKEE: Robert E. Callan. SHEBOYGAN: R. L. Zaegel.

ALASKA-BETHEL: Beryl F. Michaelson. CUBA-HAVANA: A. F. Golderos, Roberto Pedroso. PUERTO RICO-SAN JUAN: Robert F. Ranson.

Scientific Exhibitors

FORT LAUDERDALE: Alfred E. Cronkite, Leigh F. Robinson. GAINESVILLE: Mr. Charles S. Haupt. HOLLYWOOD: John H. Mickley. JACKSONVILLE: Mr. James McKelvey Jr., Mr. H. A. Schroder. KISSIMMEE: John O. Rao. MIAMI: J. Ernest Ayre, Jack W. Barrett, John E. Burch, Edward W. Cullipher, Carl H. Davis, Harold E. Davis, Miss Ruth Gurtner, Mr. James B. Hughes, Mrs. Anita W. Johnson, Miss Kola Kennedy, Mrs. Leona B. Leber, Mr. John C. Lee, Miss Barbara Millar, Irwin Perlmutter, Milton S. Saslaw, George F. Schmitt Jr., Richard E. Strain, Murray M. Streitfeld, Ph.D. ORLANDO: Eugene L. Jewett. QUINCY: Mrs. Julius C. Davis. SARASOTA: Hugh G. Reaves. TAMPA: J. Brown Farrior, J. M. Ingram Jr., Mr. L. H. Peterson, Wesley W. Wilson, Robert W. Withers. WEST PALM BEACH: W. Ambrose McGee.

GEORGIA-ATLANTA: John R. Lewis Jr. ILLINOIS-CHICAGO: Mr. George W. Cooley. NEW YORK-NEW YORK: Miss Charlotte T. North.

Other Guests

GAINESVILLE: R. S. Poor, Ph.D. HIALEAH: Mr. Donald W. Welch. HOLLYWOOD: Emanuel M. Kaplan, D.D.S. JACKSONVILLE: Miss Blois Brown, Mr. Robert G. Carter, Mrs. Doris B. Cordray, Mr. Tom Jarvis, Mrs. Mae W. Mason, Miss Edna Mae Nolan, Mrs. Zoe Pack, Mr. W. Harold Parham, Miss Garry J. Starr, Mr. Frank Winchell. MIAMI: Mr. Rodney Belcher, Miss Gracia Charron, Mr. J. Richard Eason, Mr. Thomas E. Flipse, Ann Gerivitz, RN., Mr. John H. Holly Jr., Mr. John K. McVey, Mr. Arlis I. Nimmo, Mr. Robert Rogers, Mr. L. E. Ross, Mr. L. G. Strong.

ORLANDO: Mr. Raymer F. Maguire, Mr. Louis M. Orr. PANAMA CITY: Mr. William C. Roberts Jr. ST. PETERSBURG: Mr. John Monahan, Mr. Al Morgan. SURFSIDE: Mr. Frederic W. Huber, Mrs. Helen S. Huber. TAMPA: Mr. George J. Emanuele, Mr. Hugh G. Gaffney, Miss Marion Peters, Byron G. Wilson, D.D.S.

MARYLAND-BALTIMORE: Mrs. Grace Hoenes Hartley. PENNSYLVANIA-PHILADELPHIA: Mrs. Dorothy Mendel.

Annual Joint Report of Secretary-Treasurer, Samuel M. Day, M.D. Acting Managing Director, Ernest R. Gibson

This year marks the eightieth anniversary of the Association. From the modest start in Jacksonville on August 14, 1874, it has steadily progressed into one of the strongest state medical associations in the country. It has kept pace with the remarkable growth and development of the state. For the past quarter century, the steadying hand and wise counsel of Dr. Stewart Thompson contributed mightily to the laying of a firm foundation, and upon that, erecting a solid structure which has stood the test of time. In taking stock of this rich heritage, it becomes clear that a still greater Association in the future will be assured only by the present application of the lessons of the past.

Membership

The membership at the end of the fiscal year, March 20, 1954, totaled 2,537. This represents a net increase of 122 members, since the same date in 1953.

The top ten county medical societies, from the standpoint of membership, are, in order: Dade, Duval, Pinellas, Orange, Hillsborough, Palm Beach, Broward, Polk, Escambia and Volusia.

Association Headquarters

The headquarters offices are located at 128 East Forsyth Street, Jacksonville, as they have been for nearly a quarter of a century. Members are urged to visit these offices and observe the numerous activities.

The office staff is composed of ten employees who are loyally and faithfully serving the Association. In addition to the Acting Managing Director, there is Mrs. Zoe Pack, Office Manager, and in the order of their seniority of service, Mrs. Mae Mason and Misses Blois Brown, Edna Mae Nolan, Frances Pesce and Garry Starr. The Bureau of Public Relations is headed by Mr. W. Harold Parham, aided by Mr. Tom Jarvis, Assistant, and Mrs. Doris Cordray.

First among those who contribute greatly to the functioning of the headquarters office on a contract basis is the Editorial Consultant, Mrs. Edith B. Hill. Legal counsel is provided by a Jacksonville law firm on a retainer basis and the books are audited annually by a certified public accountant.

Realizing that it is impractical for most members to visit the headquarters office, two procedures have been established which, it is hoped, will give the members a better understanding of the general operation of the Association and the activities of the headquarters office. One, a representative from the executive office will attend county medical society meetings to outline these activities and to answer questions which members and county society officials may have. Two, the Board of Governors has compiled a pamphlet which presents the Facilities, Methods and Activities of the Association in a moderately detailed form. Every member is urged to read this pamphlet, the better to know his Association and how he may better utilize its services.

The Journal

The number of Journals printed during the past fiscal year totaled 33,020 which represents a net increase of 1,029 over the previous year.

The cost of printing The Journal continues to advance, both in increased cost of printing and paper stock. A more detailed report of The Journal is contained elsewhere in this issue in the Report of the Editor.

Medical Directory

One copy of the 1954 Florida Medical Directory was mailed to each active member, without charge, in January. Additional copies are available at $2.00 each. The cost of printing the Directory has also increased yearly, due not only to the increased price of printing and paper, but also to steady increase in the number of medical doctors holding Florida licenses.

Briefs

Every attempt is made to keep the members as well informed as possible. This is accomplished mainly through the Association's newsletter, "Briefs." "Briefs" is sent

to every member but it is not issued on an established schedule. They are sent only when it is believed that there is information of value to be disseminated. They are intentionally kept short, informal and newsy.

Bureau of Public Relations

During the past year, the Bureau of Public Relations has been engaged primarily in promoting, planning and coordinating the Association's Public Relations and Legislative programs. Policies of the Bureau are determined by the Board of Governors and implemented through its Liaison Member for Public Relations and the Committee on Legislation and Public Policy. Comprehensive and long range programs have been developed and appear in the annual reports of the respective committees.

Field work has taken a great deal of the time of the Bureau's staff. The officers and committee chairmen of every county society have been contacted, many on several occasions, to promote and coordinate the programs over the state. Newspapers, radio and television stations, allied and civic organizations, legislators and other influential individuals have been contacted in an effort to bring about a closer relationship and better understanding of the Association's objectives and activities.

A Code of Cooperation between physicians, hospitals and press-radio-television has been adopted on a state level after conferences with officers of organizations representing these groups. This Code of Cooperation is serving as a guide for component medical societies to follow in promoting better relations with news media on a local level.

The Rural Health Program has been expanded in cooperation with the Florida Agricultural Extension Services of our two state universities, the State Board of Health and the Florida Farm Bureau Federation. The program now includes county level inventory of medical and health facilities, surveys to determine health problems; leading the people to an awareness of their health problems, and solving them with leadership from the county medical societies, through resources available to the respective communities. As in the past, physician speakers, literature, exhibits, displays and special services have been supplied to rural groups.

The Association's fair exhibit was displayed last October at the Pensacola Interstate Fair. Health exhibits have been displayed at the Central Florida Exposition, Lake County Fair, Suwannee County Fair, and special showings in Gainesville and Jacksonville. All showings were co-sponsored by the respective county medical society and the Association.

Publicity for the Association's annual convention, district meetings and other activities of interest have been processed by the Bureau. Health Topics on items of medical interest have been supplied regularly to weekly newspapers. Transcribed programs on health subjects have been distributed in cooperation with county medical societies for broadcasting by local radio stations.

County medical societies have been assisted by the Bureau with special projects, such as medical forums, live radio and TV programs, exhibits, improving emergency call services, press-radio-television relations and other general public relations activities.

The Bureau has assisted the Committee on Legislation and Public Policy in coordinating and carrying out projects pertaining to national legislation and our state legislative program.

The responsibility for local public relations projects rests with the respective county medical societies. The Bureau is available to county medical societies to assist and advise with local programs and they are urged to use these facilities.

Exhibits

As in the past, the success of our 1954 Convention is due in no small part to the technical exhibitors. These exhibiting firms display products and equipment of value to the members and much scientific information is available in this manner. The gross income from this source amounting to nearly $15,000 for the year 1954 is a substantial contribution to the Association's total income.

Finances

Receipts for the Fiscal Year, ending March 20, 1954, totaled $125,902.79 and the disbursements were $97,052.92. This difference of $28,849.87 is not necessarily a true picture of the excess of receipts over expenditures. The discrepancy is due to the computing of the financial statement on a fiscal year basis, while the chief source of income, dues, is received on a calendar year basis.

Although there appears to be some indication of a leveling off, the expenditures indicate that the expenses of operating the Association are still increasing. It is anticipated that the coming year will find prices of many items still higher.

The financial statements appearing at the end of this report are published for the information of the members. The books and records of the Association are open to the members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich & Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Samuel M. Day, M.D., *Secretary-Treasurer*
Ernest R. Gibson, *Acting Managing Director*

April 15, 1954

Dr. Samuel M. Day, Secy.-Treas.
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Ernest R. Gibson, Acting Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the association, maintained in his office, for the period March 21, 1953 to and including March 20, 1954, and submit herewith our report consisting of:

EXHIBIT "A" — Statement of Assets and Liabilities, March 20, 1954.
EXHIBIT "B" — Statement of Receipts and Disbursements for the Period March 21, 1953 through March 20, 1954.
EXHIBIT "C" — Analysis of Changes in Retirement Trust Fund, March 21, 1953 through March 20, 1954.

We determined that all recorded receipts were deposited to the credit of the association, and that the disbursements appeared to be for proper purposes.

In order to expedite the handling of accounting records, the books of account have been placed on a cash receipts and disbursements basis. The item on the liabilities side of Exhibit "A," under caption "Deferred Income" is the aggregate of the membership dues unpaid as at March 20, 1954 and the amount due the Journal Fund by advertisers.

The investments in U.S. Treasury and Savings Bonds were verified by actual count in the Safe Deposit Vault.

The records of the various County Societies were inaccessible and, therefore, we made no attempt to verify remittances for dues, nor did we confirm the balances due the association for advertising in the Journal.

Yours very truly,
(*Signed*) Goodrich & Varnedoe
Certified Public Accountants

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Exhibit "A"
Statement of Assets and Liabilities

March 20, 1954

Assets		
Cash in Bank:		
Atlantic National Bank—Checking A/c	$120,258.17	
Florida National Bank—Checking A/c	12,729.63	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,959.98	$134,956.95
Petty Cash Fund		25.00
Accounts Receivable:		
General Fund	$ 25,560.00	
Journal Fund	1,641.27	27,201.27
Inventory—Stationery, Etc.		2,957.20
Investments: U. S. Treasury and Savings Bonds		45,995.87
Furniture & Fixtures:		
General Fund	$11,381.93	
Less Depreciation Reserve	4,909.71	$ 6,472.22
Bureau of Public Relations Fund	$ 4,003.75	
Less Depreciation Reserve	1,425.60	2,578.15
		9,050.37
TOTAL ASSETS		$220,186.66
Liabilities		
Deferred Income		$ 27,201.27
Net Worth		192,985.39
TOTAL LIABILITIES AND NET WORTH		$220,186.66

Exhibit "B"
Statement of Receipts and Disbursements

March 21, 1953 Through March 20, 1954

Balances — March 21, 1953		
Atlantic National Bank—Checking A/c	$ 56,598.63	
Florida National Bank—Checking A/c	47,583.75	
Atlantic National Bank—Savings A/c	9.17	
Barnett National Bank—Savings A/c	1,940.53	$106,132.08
Receipts		
Back Dues	$22,520.00	
Current Dues	64,160.00	
Entrance Fees	2,260.00	$ 88,940.00
Income from Trust Fund		911.44
Interest on Savings Accounts		19.45
Miscellaneous Income		751.64
Advertising—Journal $17,118.39		
" —Directory 255.00		17,373.39
Journal Subscription & Sales		505.42
Directory Sales		1,658.00
Technical Exhibits		13,640.00
Convention Smoker		1,953.00
Reprints—Non-Member		150.45
TOTAL RECEIPTS		125,902.79
TO BE ACCOUNTED FOR		$232,034.87

Disbursements	
Administrative:	
Postage and Express	$ 1,020.12
Office Supplies	1,071.40
Telephone and Telegraph	1,153.28
Travel Expense—Acting Mng. Dir.	1,047.73
Delegates to A.M.A.(2) Transportation	597.45
Office Rent	2,850.00
Bank Exchange	4.67
Memorial to Deceased Past Presidents (To Amer. Med. Ed. Foundation)	255.00
Treasurer's Bond	225.00
Floral Arrangements	142.85
Employer's Liability Insurance	54.63
Maintenance—Office Equipment	468.78
Rental—Safety Deposit Box	12.50
Blue Cross and Blue Shield (Assn. Employees)	189.60
Federal Tax	620.37
State Sales Tax	746.88
Unemployment Compensation Fund	377.74
Federal Excise Tax	65.49

Furniture and Fixtures	1,717.02	
Books, Pamphlets, Etc.	304.87	
Payrolls	28,312.83	
Contractor Fees	2,243.06	
Retirement Trust Fund	300.00	
Journal Printing and Paper	17,477.00	
Dray	118.45	
Printing and Engraving	2,007.77	
Directory Printing, Etc.	2,258.18	
Convention Expense	4,682.22	
Miscellaneous Committee Expense	363.38	
Convention Smoker, Etc.	1,723.00	
Dues:		
Med. Soc. Executive Conf.	5.00	
Conference of Presidents	75.00	
Conf. of Presidents—Hotel Expense—Dr. Orr—Pres.	51.40	
Duval County Centennial Banquet	22.00	
Christmas Party—Staff	24.86	
Attorney—Retainer Fee	75.00	
Reprints—Non-Member	120.33	
Incidental	13.51	
TOTAL ADMINISTRATIVE		$ 72,798.37
Bureau of Public Relations:		
Postage and Express	$ 1,121.57	
Office Supplies	686.12	
Payrolls	12,732.64	
Contractor Fees	73.75	
Insurance—Blue Cross and Blue Shield	81.60	
Telephone and Telegraph	731.51	
Travel Expense—Supervisor	2,863.39	
Federal Tax	231.09	
State Sales Tax	66.91	
Unemployment Compensation Fund	165.10	
Federal Excise Tax	24.79	
Furniture and Fixtures	297.51	
Office Rent	1,422.26	
Books, Pamphlets, Etc.	402.94	
Printing and Engraving	1,297.20	
Maintenance—Office Equipment	70.43	
Legislation, Public Policy	10.00	
Special Projects	1,811.09	
Incidental	33.50	
Chamber of Commerce Membership	100.00	
Comprehensive & Liability—Auto Insurance—employees	31.15	
TOTAL BUREAU OF PUBLIC RELATIONS		24,254.55
TOTAL DISBURSEMENTS		$ 97,052.92
Balance — March 20, 1954		$134,981.95

Balance Comprised of:

Atlantic Nat. Bank—Checking A/c.	$120,258.17		
Florida Nat. Bank—Checking A/c	12,729.63		
Atlantic Nat. Bank—Savings A/c	9.17		
Barnett Nat. Bank—Savings A/c	1,959.98	$134,956.95	
Petty Cash Fund		25.00	$134.981.95

Exhibit "C"
Retirement Trust Fund
Analysis of Changes
March 21, 1953 Through March 20, 1954

BALANCE ON HAND—March 21, 1953		$17,216.81
ADDITIONS		
Transfers from General Fund	$ 300.00	
Income:		
Gross Interest on Bonds	200.00	
TOTAL ADDITIONS		500.00
TO BE ACCOUNTED FOR		$17,716.81

DEDUCTIONS:		
Distributions to Dr. Stewart G. Thompson Estate	$ 600.00	
Trustee Fee	50.00	650.00
BALANCE		$17,066.81
Bonds Transferred to Association	$16,155.37	
Principal Cash Transferred	911.44	$17,066.81
BALANCE ON HAND—March 20, 1954		.00

Exhibit "D"
Dues and Entrance Fees Collected March 21, 1953 Through March 20, 1954

Name of Society	Total Members	No. Paid Members	No. In Arrears	1954 Dues Collected	Back Dues Collected	Entrances Fees
Alachua	51	44	7	1,400.00	200.00	70.00
Bay	26	23	3	760.00	200.00	20.00
Brevard	28	16	12	520.00	160.00	30.00
Broward	106	94	12	3,400.00	960.00	200.00
Columbia	11	9	2	280.00	80.00	10.00
Dade	659	419	240	14,720.00	9,400.00	560.00
DeSoto-Hardee-Highlands-Glades	26	23	3	680.00	120.00	50.00
Duval	261	172	89	5,360.00	4,040.00	230.00
Escambia	92	90	2	3,080.00	400.00	80.00
Franklin-Gulf	9	6	3	160.00		30.00
Hillsborough	177	129	48	4,480.00	1,400.00	50.00
Indian River	9	9	0	240.00	80.00	20.00
Jackson-Calhoun	19	15	4	480.00	40.00	10.00
Lake	27	4	23	40.00	80.00	20.00
Lee-Charlotte-Collier-Hendry	36	34	2	1,240.00	40.00	60.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	55	40	15	1,240.00	320.00	10.00
Madison	4	4	0	120.00		
Manatee	22	19	3	720.00	320.00	50.00
Marion	29	19	10	560.00	400.00	30.00
Monroe	12	11	1	320.00	240.00	10.00
Nassau	11	6	5	120.00	40.00	
Orange	182	157	25	5,840.00	520.00	190.00
Palm Beach	131	127	4	4,800.00	640.00	100.00
Pasco-Hernando-Citrus	18	15	3	440.00		
Pinellas	206	192	14	6,520.00	760.00	170.00
Polk	93	15	78		400.00	10.00
Putnam	9	9	0	280.00	40.00	
St. Johns	19	19	0	640.00		40.00
St. Lucie-Okeechobee-Martin	18	14	4	360.00	120.00	30.00
Sarasota	54	46	8	1,560.00	720.00	80.00
Seminole	18	18	0	600.00		10.00
Suwannee	9	7	2	160.00	80.00	10.00
Taylor	4	1	3		120.00	
Volusia	83	70	13	2,440.00	600.00	70.00
Walton-Okaloosa	17	17	0	480.00		
Washington-Holmes	6	5	1	120.00		10.00
Totals	2,537	1,898	639	64,160.00	22,520.00	2,260.00

Dues Not Payable			22,520.00 Back Dues Collected
Co. Soc. Secys.	34		
Life	103		86,680.00 Total Dues Collected
Excused	26		2,260.00 Entrance Fees Collected
Honored	75		
Military Serv.	56		
		294	
Paying Dues		1,604	88,940.00 Dues and Entrance Fees

Report of Editor of The Journal
Shaler Richardson, M.D.

The Journal of the Florida Medical Association is now entering its forty-first year of publication. It has been my privilege to be associated officially with The Journal for 29 of the years of its existence, all but three of them as Editor. Your confidence in re-electing me to the editorship year after year has been most gratifying. I hope that I have contributed in some small measure to the continuing success of The Journal, for my compensations have been many.

We are all proud of the top-ranking position of our Journal among state medical journals. Only your contributions have made this possible. It is after all the scientific articles that make a success of a journal such as ours.

Membership in our Association has steadily increased through the years. Current figures show the average monthly circulation of The Journal to be 2,680. In March, 2,865 Journals were mailed. Of these, 2,405 went to members, the remainder being sent to individual subscribers, advertisers and exchanges. The Journal has subscriptions going to Australia, Argentina, Germany, Italy, England and the several United States possessions. Requests for reprints of scientific articles come to The Journal from all over the world.

Printing costs and price of paper stocks have both risen appreciably during the past year. We have found it necessary to cut down on the number of exchange and complimentary copies being sent out.

Forty-nine scientific papers were published during the past fiscal year, of which 39 were by members. Fifteen of the papers published, 11 by members and four by guest speakers, were read at the 1953 meeting in Hollywood. In addition, the Committee on Publication accepted six papers from non-members because these papers contained timely scientific information of interest to many of our members.

A scientific article on snake bites by Dr. Edwin H. Andrews and C. B. Pollard, Ph.D., of the Department of Chemistry of the University of Florida, read at last year's annual meeting and published in the December issue of The Journal, was received with interest throughout the country. Dr. Frederick H. Bowen's article on "The Treatment of Post-Thrombophlebitic Changes in the Legs by Various Surgical and Conservative Means" won the Duval County Medical Society prize for the best scientific paper by a member of the society last year. This paper was presented at last year's meeting of the Association and was published in the October issue of The Journal.

Also published in the October Journal was Dr. Louis M. Orr's address on "Medicine at the Crossroads: 1933-1953," which was read before the Conference of Presidents and Other Officers of State Medical Associations, of which Dr. Orr was president-elect. This paper was published in other medical journals throughout the country.

We believe that our editorial and commentary section is outstanding among such sections in state medical journals. We have endeavored to keep these pages sufficiently diversified so that all members will find something of interest. We hope that you have found them timely and informative. Of outstanding interest this year was the December editorial on St. Luke, entitled "The Beloved Physician," by Dr. Frank G. Slaughter, a member of our Association and a well known author and Biblical authority.

One subject covered this year both in a scientific article by Dr. Lorenzo L. Parks and editorially was the problem of speeding ambulances. An article on malpractice insurance by your Secretary-Treasurer, Dr. Samuel M. Day, published in the March issue was especially interesting and timely in these days of rising insurance rates.

During the past year 75 abstracts of articles published by our members in other journals were published in The Journal. These serve as a valuable guide to members seeking information on many scientific subjects. The staff is constantly scanning other journals for articles written by our members. There is no assurance that some valuable papers may not be missed. You can add greatly to the value of this section by sending us reprints of your articles published in out-of-state medical journals.

News Items and Component Society Notes are two features in which members are always interested. These are taken from county society bulletins, newspaper clippings and information sent in by members and county societies. Many items of interest, however, are missed. These two sections could be far more informative with more contributions from the members.

Other sections of note are From Our President, Florida Blue Shield, State Board of Health, Books Received, Births, Marriages and Deaths, Obituaries, Medical Licenses Granted and the Woman's Auxiliary. For your convenience, The Journal carries a list of Association officers and committee members, a schedule of meetings of certain medical organizations and a tabulation of county societies together with their presidents, secretaries, meeting dates and current membership. These should be invaluable to the members, particularly to Association officers, committeemen and county society officials. Yet the headquarters office receives many inquiries the answers to which are in The Journal.

President Frederick K. Herpel presented interesting and informative messages on the President's page during his administration. Dr. Herpel covered a variety of subjects such as his Formula for Living, suggestions for the improvement of county medical societies and our obligations to the medical schools of America.

A new feature of The Journal is a section on what "Others Are Saying." This is to appear first in the May issue and will contain items of interest taken from other medical publications.

The February Journal contained a full page color reproduction of the Oath of Hippocrates. Reprints of this Oath suitable for framing were sent to members requesting them. Requests for these reprints came from officials of the American Medical Association as well as from many other allied organizations throughout the country.

I wish to express appreciation to the Assistant Editors, Drs. Webster Merritt and Franz H. Stewart, and to the Associate Editors, Drs. Louis M. Orr, Joseph J. Lowenthal, Jere W. Annis, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar and Walter C. Payne Sr.

The assistance of Drs. Chas. J. Collins and James N. Patterson, who have served with me on the Committee on Publication, has been invaluable. They have read and approved the scientific articles published in The Journal before they were finally referred to me. This service takes time and effort which should merit the special appreciation of the membership.

Dr. Kenneth A. Morris, Chairman, and his assistant, Dr. Walter C. Jones, are responsible for the smooth functioning of the Abstract Department. We are greatly indebted to them.

Special credit goes to Mrs. Edith B. Hill, Editorial Consultant and Manuscript Editor. We are indeed fortunate to have on our staff a professional medical writer whose services cover all the refinements of medical journalism.

The Journal was extremely fortunate in having Mr. Ernest R. Gibson take over where Dr. Stewart Thompson left off as Managing Editor. He had had years of invaluable experience working with Stewart on The Journal. I wish to express appreciation to Mr. Gibson for a difficult task well done.

The detail work of getting The Journal ready for publication each month is performed by Miss Blois Brown, our alert and capable Journal Technician.

The Journal is YOUR Journal. It can be only as good as you make it. Comments and criticisms are always welcome. Only when the members make known their desires will The Journal staff be able to give them the kind of publication they would like to have.

Respectfully submitted,
Shaler Richardson, M.D., *Editor*

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PROCEEDINGS

EIGHTIETH ANNUAL

MEETING

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DUNCAN TRACY MCEWAN, M.D., PRESIDENT

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Dr. Duncan Tracy McEwan, the son of William L. and Katherine Lippitt McEwan, was born in Cooperstown, N. Y., on Nov. 13, 1902. He was awarded the degree of Bachelor of Arts by Cornell University in 1925 and three years later received the degree of Doctor of Medicine from Cornell University Medical College in New York City. There followed a two year rotating internship at the Methodist Episcopal Hospital in Brooklyn, N. Y. In 1930, he began a five year preceptorship in surgery with Dr. John S. McEwan and Dr. Gaston Edwards of Orlando.

Through the years, Dr. McEwan has been prominent in medical circles of Orlando and of the state. At Orange Memorial Hospital in Orlando he is attending surgeon, chief of a surgical service and a past president of the staff. In 1944, he was president of the Orange County Medical Society.

A member of the Board of Governors of the Florida Medical Association since 1944, he served as Chairman of that body in 1948. He formerly was a member of the Association's Committee on Tuberculosis and Public Health, of the Medical Advisory Committee of the Rehabilitation Service, and of the Executive Committee of the Blue Shield of Florida. Also, he has served as state chairman of the War and Post-War Planning Committee of the Florida Tuberculosis Association and as a representative of the American College of Surgeons to the Florida Cancer Council.

Dr. McEwan is a fellow of the American College of Surgeons and the International College of Surgeons. He also holds membership in the Southeastern Surgical Congress, the American Goiter Association and the American Medical Association.

Locally, Dr. McEwan is a member and past director of the Rotary Club, a member and director of the Orlando Country Club, and a member and past director of the University Club. His social fraternity is Lambda Chi Alpha and his medical fraternity Nu Sigma Nu. His hobby is golf.

In 1935, Dr. McEwan and Miss Marion Friess of Brooklyn, N. Y., were united in marriage. They have one son, Bruce, a student at Deerfield Academy.

Eightieth Annual Convention

Attendance at the eightieth annual convention in Hollywood, April 25-28, broke all previous records again this year. The total registration was 1,827. Included in this figure are 1,082 physicians, 38 non-physician guests, 438 members and guests of the Woman's Auxiliary, 14 scientific exhibitors and 255 representatives of exhibiting firms. Twenty-five other states and Alaska, Cuba and Puerto Rico were represented. The complete registration list is published at the end of the proceedings on page 925.

Just prior to the adjournment of the Second House of Delegates, Dr. Duncan T. McEwan of Orlando, who has served the past year as President-elect, was installed as President. At that time he was presented a personal gavel by Dr. Frederick K. Herpel, retiring President. The gavel is encircled by a silver band engraved with Dr. McEwan's name and the year of his administration.

Other officers elected for the coming year are Drs. John D. Milton of Miami, President-elect; V. Marklin Johnson of West Palm Beach, First Vice President; Frederick H. Bowen of Jacksonville, Second Vice President, and Rowland E. Wood of St. Petersburg, Third Vice President. Re-elected to office were Drs. Samuel M. Day, Secretary-Treasurer, and Shaler Richardson, Editor of The Journal, both of Jacksonville.

Dr. McEwan presented to Dr. Herpel the past president's button and certificate of honor. He paid tribute to Dr. Herpel for his "great force of character, high ideals and administrative ability."

Four Scientific Assemblies, two General Sessions and two meetings of the House of Delegates were crowded into two and one-half days, Monday morning until Wednesday noon. Dr. Frederick K. Herpel gave his presidential address at the first meeting of the House of Delegates on Tuesday morning. The guest speaker, Dr. Wilburt C. Davison, presented a paper during the Second General Assembly, which was held following adjournment of the first meeting of the House of Delegates.

The three reference committees appointed by the President gave careful consideration to committee reports and resolutions presented at the first meeting of the House of Delegates. Their study and recommendations on these measures aided greatly in the dispatching of business at the second meeting of the House.

The entire Great Lounge of the Hotel was turned over to technical exhibits. The scientific exhibits were displayed in the Arcade on the ground floor and in the lobby. These exhibits presented a wealth of information on varied subjects. Officers and members of the Association are appreciative of the contributions of these exhibitors.

On Sunday the facilities of the Hollywood Beach Hotel were taxed to provide assembly rooms for the simultaneous meetings of seventeen specialty groups and the Florida Cancer Council, Blue Shield of Florida, and the Florida Medical Committee for Better Government. Several out-of-state speakers who addressed specialty groups also appeared on the Association's scientific program.

The time and effort contributed by the Convention committees on smoker, golf, anglers, Woman's Auxiliary advisory, and the Association dinner, contributed greatly to the success of the 1954 convention.

Members and guests enjoyed a gala "Carnival" at the Hollywood Beach Hotel pool patio during the annual smoker on Monday evening. Refreshments and dancing were enjoyed. The huge hotel dining rooms were filled to near capacity on Tuesday evening at the Association dinner.

The 1955 convention will be held at the Vinoy Park and Soreno Hotels in St. Petersburg. The dates for this meeting have been set by the Board of Governors for April 3-6.

Convention Golf Tournament

The annual Florida Medical Association Golf Tournament was held again this year at the Hollywood Beach Hotel Golf Course. Winning scores were determined on the basis of 18 holes. Names of the winners were announced and prizes awarded at the Annual Dinner on Tuesday evening.

The Orlando Cup for low net scorer was won by Dr. James T. Shelden of Lakeland. Dr. Shelden also won the Keleket X-Ray Trophy for the third year in a row and retired the Trophy. This Trophy is awarded annually to a member of the radiological group.

The Duval Trophy for low gross score was awarded to Dr. David W. Martin of West Palm Beach.

Runner-up prizes were awarded to Dr. Milton C. Maloney of Jacksonville for low gross score and to Dr. James A. Poyner of Panama City for low net score. Dr. L. Washington Dowlen of Miami won the prize for having the most three's. Prize for the highest score was won by Dr. Robert J. Jahn of Winter Haven.

The Orlando Cup was donated by the Orange County Medical Society in 1931, and the Duval Trophy was donated by that Society in 1952.

Convention Anglers

Prizes to anglers were announced Tuesday evening at the Association dinner. All of the awards were won this year by Tampa doctors.

Awards for the largest, longest and smallest sailfish were all three awarded to Dr. Paul J. McCloskey. The sailfish weighed 47 pounds and was 7 feet, 5 inches long. The prizes were a radio, sphygmomanometer, and a tuxedo.

Dr. Thomas F. Nelson who caught a kingfish 3 feet, 9 inches long and weighing 21 pounds, was awarded a gold watch. Dr. Nelson also caught a tuna weighing 11 pounds, which was 2 feet, 8 inches long.

Dr. Wesley W. Wilson was presented with a medical bag for catching a rare cobia, 3 feet, 7 inches long and weighing 21 pounds. Dr. James B. Hodge Jr. of Tampa was awarded a sweater for his catch, a dolphin 3 feet, 10 inches long, which weighed 19 pounds.

Jenkins-Keogh Measure An Important Step Away From the Welfare State?

"Why Not Encourage the Self-Employed to Build Their Own Retirement Funds?" Under this caption The Saturday Evening Post in the April 24 issue commented editorially on the Jenkins-Keogh bill, introduced last year and now under consideration by the Congress. In the opinion of Frank Dickinson, Ph.D., director of the Bureau of Medical Economic Research of the American Medical Association, this editorial "is the best short piece written so far on voluntary pensions for the self-employed and the pensionless employed."

Employed persons in this country may look forward at least to partial protection in their old age by social security and in many instances by company pension funds also, with payments into such funds deductible from taxable income. Self-employed persons, on the other hand, such as physicians, lawyers and farmers, face the obstacle of exorbitant taxation in their efforts to provide for retirement. The Post editorial cites the recent case of a physician who gave up a large and presumably profitable practice to accept a position in a government hospital in order to receive the benefits of a pension fund because he had been unable to educate his children and at the same time save enough to provide for eventual retirement. It also points out that the young physician or lawyer, after a long and expensive education and apprenticeship, is apt to find it practically impossible to save adequately under present conditions.

In an effort to correct this inequity, the Jenkins-Keogh measure provides that a person ineligible to participate in a pension or profit-sharing plan may set aside yearly an amount not to exceed 10 per cent of his earned income, and at most no more than $7,500, to be paid into a restricted retirement trust or insurance annuity. The amount could be deducted from taxable income. The fund could not be tapped, "except in the case of total disability," until the taxpayer is 65 years old, and there are certain restrictions on the means of accumulating these savings.

The proposed law would thus roughly place the self-employed on an equal footing with the employed who are beneficiaries of private pension funds. True, there might be additional advantages; for example, the self-employed doctor building up his own retirement fund would be free to change communities while the beneficiary of some company pension funds would forfeit his equity in a pension when he accepts a position with a new company. "There are undoubtedly other discrepancies," says the Post editorial, "but if an individual can do better on his own account than through a company pension fund, this might be an important step away from the welfare state. Private saving should be made at least as attractive as reliance on contributions by employers or the Government."

The editorial further comments that few reliable estimates have been made of the possible loss of revenue to the government under such a law and concurs in the opinion of a writer in the Harvard Law Review that "even the possibility that the revenue loss would be so considerable as to necessitate higher tax rates is not a valid objection; it seems more equitable to distribute the

tax burden among all taxpayers than to continue discrimination against one group."

This timely comment in the Post will be of interest to the many members of the Florida Medical Association who, as mentioned editorially in the May Journal, expressed preference for the Jenkins-Keogh type of legislation in their response to a recent questionnaire on extension of social security to include physicians, sent out by the Committee on Legislation and Public Policy.

Music Hath Charms Therapeutically

Since the ancients discovered that "music hath charms to soothe a savage breast," the powers of a tune have been used for a thousand practical purposes. Not the least of these is as a therapeutic modality. Relatively new as a tool of medicine, musical therapy gained favor in service hospitals during World War II and has now become a well established procedure.

Arrington[1] reported recently that in acutely ill patients music often produces effects of sedation and reassurance, while in chronically ill patients it is able to divert the mind during long periods of convalescence and enforced rest. Background music, records, books, musical instruments and singing all help to while away tedious hours and to lift flights of the imagination to more pleasant and relaxing spheres of thought for patients with tuberculosis, rheumatic fever, malignant tumors, neurologic diseases, orthopedic disorders, and many other chronic ailments. This author also regarded music as a useful adjunct to physical therapy. Piano playing, for example, provides a most helpful contraction-relaxation pattern for strengthening the upper extremities. Too, it has been observed that digital motion in patients with contractures due to burns is frequently much improved by the playing of the piano. Likewise, trumpet exercises not only strengthen the chest and neck muscles but also the morale, as many a soldier will testify.

Soothing, rhythmic music, according to Pichot,[2] makes mentally defective persons easier to handle. In military hospitals during World War II the spirits of a depressed patient generally could be raised through a series of musical selections if one would start with somber compositions and make the selections increasingly brighter. Often, excited patients were subdued through a reversal of this process. Musical therapy is in use at the Florida State Hospital at Chattahoochee and the Florida Farm Colony at Gainesville.

Light[3] regarded music in the operating room as a beneficial adjunct to the administration of local, regional, or spinal anesthesia and as a means of diminishing apprehension in patients. Under the title of "Surgical Sonatas," editorial comment was made in the November 1950 issue of The Journal on the use of music to soothe the surgical patient, whether adult or child. Some obstetricians use this means to allay anxiety and raise the pain threshold during arduous hours spent by patients in the labor room. A survey of a group of patients undergoing various major surgical operations indicated a most favorable response to the calming effects of music.

Music is especially applicable as a therapeutic aid for children.[4] A tuneful accompaniment to a story told in simple words pleases most children. Such music is useful in games, is a pleasant distraction from the disturbing cries which invade pediatric wards of hospitals, and is of special value to children who are chronically ill and must remain in bed for long periods of time.

In dentistry, too, music allays anxiety, raises the pain threshold, and improves the doctor-patient relationship. In many offices, dentists resort to background musical recordings while they perform annoying dental procedures.

Musical therapy as a profession is now coming into its own. The first course in this subject to be taught in the South will be offered next fall by the School of Music of Florida State University in Tallahassee, according to Dean Karl O. Kuersteiner. In 1950, the National Association for Music Therapy was founded for the purpose of developing this profession. Its first published Proceedings[5] cover the historical development of musical therapy from the World War I period through World War II when the greatest progress was made in Army hospitals. The Music Department of Michigan State College in 1944 pioneered in setting up a four year course of study leading to a Bachelor's degree. An internship in music therapy was then established at Wayne County Hospital in Eloise, Mich. Since that time a number of colleges have offered training in cooperation with nearby hospitals. National standards are in process of being studied.[6]

The broad basis of the course of study is outlined in these words: "Knowledge of the dynamics of music and its effects on the human organism requires an awareness of many related subjects,

far beyond the conception of music as an art. In order to understand the basic philosophy underlying the functional use of music in relation to personality organization, one should have at least a working knowledge of anthropology, psychology, biology, physiology, physics, esthetics, philosophy, psychiatry, sociology, metaphysics, musicology and music education."[5] Persons seriously interested will find an excellent "Bibliography on Music Therapy" in the volume, *Music Therapy, 1951,* published by the National Association.[6]

1. Arrington, G. E., Jr.: Music in Medicine, West Virginia M. J. 49:152 (June) 1953.
2. Pichot, F.: Effect of Music on Mental Defectives, Ment. Health 9:6 (Aug.) 1949.
3. Light, G. A.: Use of Magnetic Recorder, Anesth. & Analg. 28:330 (Nov.-Dec.) 1949.
4. Music as a Therapeutic Modality, J. A. M. A. 153:219 (Sept. 19) 1953.
5. National Association for Music Therapy, Chicago, Illinois, 1952, vol. 1.
6. Music as a Therapeutic Aid, New York State J. Med. 54:622-623 (March 1) 1954.

"A Family Doctor For Every Doctor's Family"

"The general practitioner is the backbone of American medicine," President Edward J. McCormick of the American Medical Association told the American Academy of General Practice at its Cleveland meeting recently. "Whatever we do to expand the opportunities of general practice will eventually help us to overcome many of the difficulties we are meeting every day on the national level in the way of criticism directed at the medical profession as a whole." So why not begin at home and in the interest of self preservation expand the opportunities of general practice on our own doorstep, thereby providing a bright and shining example to the laity?

Could it be that, like the cobbler's children who have no shoes, the doctor's family may be getting the poorest medical care and attention? The American Academy of General Practice seems to think so for it is enlisting the support of the various medical organizations of the country in a unique project which is receiving high priority support during 1954. "A Family Doctor For Every Doctor's Family" is the slogan which best describes the project.

The academy was inspired to embark upon this undertaking by Dr. Merrill Shaw, academy vice president, who had been critically ill at his home in Seattle. In outlining his idea Dr. Shaw said he was convinced that physicians and their families received "hopscotch" medical attention, neglect their own health and seldom have a thorough check-up. In fact, he could not recall that a single doctor had ever come to him for a physical examination during the 20 years he had engaged in general practice. He provided records to show that the country is losing many highly trained doctors at the peak of their careers. Many of the deaths are due to preventable illness. It was his estimate that over half the physicians in private practice work 60 or more hours a week. Their failure to practice what they preach may result in many premature deaths.

Of 45 members of the Florida Medical Association whose obituaries appeared in The Journal during the last 12 months, 26, or 58 per cent, were 65 years of age or younger at death. The average age was 68. Four were in the eighties, 11 in the seventies, 11 in the sixties, 10 in the fifties, 4 in the forties and 5 in the thirties.

The academy is leading a campaign now in progress to have every physician arrange for the services of a family doctor for himself and his family. It is being promoted especially among women's auxiliaries of state and county medical societies and certainly is worthy of thoughtful consideration. By cooperation, the life you save may be your own or that of a member of your family.

A Study in House Calls

An excellent demonstration of the opportunities to engage in research in small communities is afforded by a study recently undertaken to obtain statistical information on house calls. As commented editorially in both The Illinois Medical Journal[1] and the New York State Journal of Medicine,[2] the results of the study made by Couter, Held and York[3] of Decatur, Ill., proved both interesting and practical.

These investigators discovered after making 1,000 consecutive residence visits that one out of every four calls was not warranted because the patients could have been seen in the office. Only 8.2 per cent of the visits were necessary within four hours; in 4.3 per cent a 12 hour time lag would have been permissible; in 62.6 per cent the complaints were not urgent, but for various reasons the patients were unable to visit the office; and in 24.9 per cent the patient could easily have been seen in the office.

The time distribution was: 325 visits between

7 a.m. and noon; 311 between noon and 6 p.m.; 206 between 6 and 8 p.m.; 111 between 8 p.m. and midnight, and 47 after midnight. Fifteen of the 47 patients, or 31.9 per cent, required a physician within four hours, and 27, while symptomatic, could have been seen the following morning; 1 had to be seen within 12 hours, and the remaining 4 needed neither physical therapy nor emotional reassurance at that hour.

The high incidence of visits to those over 65 years of age served to emphasize the importance of geriatric medicine. Women outnumbered men in the series. The over-all percentage of female patients was 65.5 per cent as compared to 34.5 per cent for male patients.

In the course of the 1,000 house calls, the physicians encountered 135 different diseases, 14 of which covered 66.4 per cent of the total number of calls, leaving 121 others distributed through the remaining 336 visits. The commonest clinical entities in order of frequency were: influenza, follicular tonsillitis, nasopharyngitis, pneumonia, gastroenteritis, anxiety state, cardiac failure, bronchitis, acute back pain, urinary tract infection, coronary artery disease, cholecystitis, cerebrovascular accident, and bronchial asthma.

The drugs most frequently needed in the doctor's bag numbered 16: aspirin compounds, penicillin with or without streptomycin, soporifics, barbiturates, meperidine (Demerol) hydrochloride, Triple Sulfas suspension (combination of sulfadiazine, sulfamerazine, sulfamethazine, and alcohol), cough syrup, morphine, aminophylline intravenously, meralluride (Mercuhydrin) sodium, sodium salicylate orally and parenterally, dihydroergotamine methanesulfonate (D.H.E. 45), dimenhydrinate (Dramamine) parenterally, Kaopectate, diphenhydramine (Benadryl) hydrochloride parenterally, and codeine orally.

Used sparingly were 14 other drugs, but their presence in the bag was considered vitally necessary. These were: digitoxin orally and parenterally, camphorated opium tincture, amobarbital (Amytal) sodium parenterally, epinephrine (Adrenalin) in oil, atropine parenterally, quinidine orally, glucose intravenously, methantheline bromide (Banthine) parenterally, pentylenetrazol (Metrazol), nitroglycerin (glyceryl trinitrate), procaine amide (Pronestyl) hydrochloride intravenously, neostigmine (Prostigmin) parenterally, calcium gluconate parenterally, and methantheline bromide orally.

This interesting analysis of a local problem in a city of 70,000 with a strong tradition of residence visits invites other studies. Doubtless a somewhat similar pattern would emerge in various geographic areas, although such factors as seasonal variations or variations in age distribution of the local population might alter it to some extent.

1. House Calls, Illinois M. J. 104:333 (Nov.) 1953.
2. House Calls, New York State J. Med. 54:766 (March 15) 1954.
3. Couter, W. T.; Held, A. T., and York, C. L.: Analysis of One Thousand Consecutive Residence Visits to Acutely Ill Medical Patients, J. A. M. A. 152:1704-1706 (Aug. 29) 1953.

Short Course Program July 12-16, 1954

The Twenty-Second Annual Graduate Short Course for doctors of medicine will be held at the George Washington Hotel in Jacksonville the week of July 12-16, 1954. Distinguished teachers will lecture on Medicine, Pediatrics, Surgery and Gynecology, and in addition there will be six lectures on Practical Psychiatry presented by Dr. Hans Lowenbach of the Duke University School of Medicine.

On Tuesday, July 13, and Thursday, July 15, after the last lecture of the day there will be a boat ride on the St. Johns River, with the compliments of the George Washington Hotel, honoring the faculty and the attending physicians and their wives. On Wednesday, July 14, at 5:30 p.m. at the usual cocktail hour sponsored by Sharp and Dohme Division of Merck and Company, there will be a reception in honor of Dr. George T. Harrell, Dean of the College of Medicine of the University of Florida.

The members of the faculty are:

Medicine: Dr. George T. Harrell, Dean, College of Medicine, University of Florida, Gainesville.

Surgery: Dr. Barton McSwain, Associate Professor of Surgery, Vanderbilt University School of Medicine, Nashville, Tenn.

Pediatrics: Dr. Robert E. Cooke, Associate Professor of Pediatrics and Physiology, Yale University School of Medicine, New Haven, Conn.

Gynecology: Dr. Conrad G. Collins, Professor and Chairman, Department of Obstetrics and Gynecology, Tulane University of Louisiana School of Medicine, New Orleans, La.

Psychiatry: Dr. Hans Lowenbach, Professor of Psychiatry, Duke University School of Medicine, Durham, N. C.

SCHEDULE FOR SHORT COURSE

HOUR	Monday July 12	Tuesday July 13	Wednesday July 14	Thursday July 15	Friday July 16
8:00	**Registration**				
9:00	**Medicine** "Mode of Action of Chemotherapeutic Agents" Dr. Harrell	**Medicine** "Virus Hepatitis" Dr. Harrell	**Psychiatry** "Convulsive Disorders" Dr. Lowenbach	**Surgery** "Neoplastic Disease of the Skin" Dr. McSwain	**Gynecology** "Urinary Incontinence" Dr. Collins
10:00	**Pediatrics** "The Use of Potassium in Fluid Therapy" Dr. Cooke	**Psychiatry** "Psychiatric Emergencies" Dr. Lowenbach	**Pediatrics** "Sexual Precocity" Dr. Cooke	**Gynecology** "Use of Tracheotomy in Severe Toxemia and Eclampsia" Dr. Collins	**Surgery** "Surgical Diseases of the Breast" Dr. McSwain
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Psychiatry** "Introduction to Neurosis" Dr. Lowenbach	**Pediatrics** "Hyaline Membrane Disease" Dr. Cooke	**Medicine** "The Enigma of Sarcoidosis" Dr. Harrell	**Surgery** "The Surgical Diseases of the Spleen" Dr. McSwain	**Gynecology** "Diagnosis and Management of Some Complications in Gynecologic and Obstetric Surgery — Part I" Dr. Collins
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
2:00	**Pediatrics** "Symptomatology of Renal Disease in Children" Dr. Cooke	**Psychiatry** "Mental Deficiency or Alcoholism" Dr. Lowenbach	**Psychiatry** "Treatment of Psychiatric Disorders in the Office of the General Practitioner" Dr. Lowenbach	**Gynecology** "Cancer of the Vulva" Dr. Collins	**Surgery** "Neoplastic Diseases of the Stomach" Dr. McSwain
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
3:15	**Psychiatry** "Psychiatric Symptomatology" Dr. Lowenbach	**Medicine** "Dangers of Obscuring Serious Disease by Early Treatment of Mild Symptoms" Dr. Harrell	**Pediatrics** "The Etiological Diagnosis of Growth Retardation" Dr. Cooke	**Surgery** "Malignant Tumors in the First Two Decades of Life" Dr. McSwain	**Gynecology** "Diagnosis and Management of Some Complications in Gynecologic and Obstetric Surgery — Part II" Dr. Collins
4:15	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
4:30	**Medicine** "Cellular Changes of Sodium and Potassium in Man" Dr. Harrell	**Pediatrics** "The Etiological Diagnosis of Anemia in Childhood" Dr. Cooke	**Medicine** "Complications and Contraindications to Therapy with ACTH and Cortisone" Dr. Harrell	**Gynecology** "Management of Pelvic Abscess" Dr. Collins	**Surgery** "Neoplasms of the Large Intestine" Dr. McSwain
		Boat Ride on St. Johns River — Compliments of George Washington Hotel	Reception for Dr. Harrell at the Cocktail Hour	Boat Ride on St. Johns River — Compliments of George Washington Hotel	

OTHERS ARE SAYING

Physician Veterans Eligible for Payments

John L. Krause, M.D.
Chicago

*Physician veterans and their families may lose substantial amounts by not applying for credits due under Social Security laws.**

A new ruling credits any veteran on active duty in any branch of the armed forces between September 16, 1940 and December 31, 1953 with $160 for each month of service toward Social Security benefits, if he served at least ninety days and was not dishonorably discharged. This ruling may mean as much as $10,000 in benefits to a physician veteran or his family.

Benefits under the Social Service laws fall into two groups: survivor's benefits and retirement benefits.

Survivor's Benefits

To be eligible for survivorship benefits, a veteran must have served at least eighteen months on active duty. Since Social Security coverage was extended on January 1, 1951, all former credits, including those earned in service, may be effective from that date.

Moreover, for each quarter year of active military service, the veteran will be insured for another quarter year subsequent to 1950, thereby doubling the insured period. For example, a physician on active duty for five years now has ten years of coverage, starting from January 1, 1951. A physician with only eighteen months of military service would be insured for three years, starting January 1, 1951, and so on.

In the event of the insured's death during the time of coverage, a widow with two or more minor children would be entitled to no less than $40 monthly until the children reach 18 years of age.

Once the insured period elapses, no benefits are payable unless the veteran is covered by Social Security by being in what is known as covered employment. Ordinary medical practice is not covered employment.

However, some physicians may have accumulated Social Security benefits before or since the period of military service and these credits will be added to those accumulated in service, increasing the benefits accordingly.

Retirement Benefits

To be eligible for retirement benefits, an individual must acquire a fully insured status before the age of 65. To do this may require as many as 40 calendar quarters, a total of ten years of coverage between January 1, 1937 and the date of retirement at 65.

Since medical practice is usually not covered employment, a physician would not ordinarily be eligible for this benefit. However, in some cases a physician's military service may supplement time spent in covered employment before entering medical practice to such an extent that a total of 40 calendar quarters will be earned. The physician will thus be fully insured upon retirement, providing income to the man and his wife for life.

January 1, 1951, as the effective starting date for Social Security credits earned in military service, applies to veterans of World War II. Veterans with active military duty after World War II and before December 31, 1953 may use September 1, 1952 as the effective starting date.

Social Security payments are not made automatically. The application must be made by the veteran or his survivor on forms supplied by the Social Security Administration field offices. A Social Security card is not necessary in order to receive military wage credits. These credits are put into the record when application for claims are made.

Veterans previously employed under Social Security may check their records by requesting postcard Form OAR-7004 from the Social Security Administration field offices.

Survivors of those physician veterans who died while in service or subsequent to discharge, even though no other Social Security coverage may exist, may now be eligible for survivor benefits. Back payments, however, will be made for no more than six months.

In addition, a lump sum payment amounting to not less than $75, will be made if the veteran's death occurred later than August 1952. The person entitled to this payment has two years from the date of death in which to claim the amount.

*Social Security benefits for the physician-veteran. Chicago M. Soc. Bull. 56:238-239, 1953.

—Modern Medicine, February 1, 1954

Gently Truthful or Brutally Frank

When a patient enters your office, that patient enters in search of truth about his illness. If his illness be a minor one with a favorable prognosis, then frankness and simplicity prevail, truth is evident and is, as a rule, easily conveyed to the patient either in words or in end results. Were all patients as easily treated as this then the practice of medicine would be an exact science and simple to exercise, indeed. We, as physicians, know that the practice of medicine is not an exact science; that it is an art, an art which can be acquired only with sound basic training mellowed by experience and administered with understanding and sympathy.

In the case of a patient with a severe and complicated illness and a guarded or unfavorable prognosis the truth can become complex. Some patients cannot accept the whole truth at one time. Truth must be gradually administered in desensitized doses. This is where the individual physician's judgment and art enter the picture. Herein lie the variations in men of medicine.

In the case of advanced malignancy or terminal disease of other types with a fatal prognosis the problem of truth may become even more complex. Hope in the most hopeless case must be utterly and brutally destroyed. When you destroy hope you destroy life, and it is not the duty of a physician to destroy life. Every physician has, of course, patients of variable personalities and dispositions, and some are trying at times. But remember, more physicians are condemned for lack of understanding and sympathy than for lack of professional knowledge or skill. Patients expect understanding and sympathy of their physician. At times illness is of secondary importance to a confused mind and soul.

Again, remember when you present the facts it is not only what you present but how you present them that marks you as a true physician. You can be gently truthful or brutally frank.

Martyn Schattyn, M.D.

—Missouri Medicine, January 1954

The Hours Are Long

For a young man or woman who wants the kind of life that goes with a forty-hour work week, a career in Medicine is a bad choice. According to a survey reported by Rusk and coworkers, in the *New England Journal of Medicine* for October 22, 1953, a practicing physician works more than sixty hours a week until after he is 45 years old. Then he slows down to an average of about fifty-five hours a week while he is in the 45-54 age group, and to about fifty hours a week while he is in the 55-64 bracket. Even at age 65, the odds are three to one against full retirement; probably he will keep right on working twenty-five or thirty hours a week until he dies.

Some people have the idea that a doctor has no cause to complain about the long hours he works. After all, they reason, he gets paid for his work; the more hours, the more income. Although there is some truth in this, the monetary reward is surprisingly small. Thus, the analysis by the Rusk group shows that physicians' average net income during 1949 ranged from $3.71 an hour, in areas where physician-population ratio was high, to $3.81 an hour in localities that were more poorly staffed.

A good many doctors under 45 years of age would like to find a way to shorten their working hours. Three approaches might be considered: (1) an increase in the number of practicing physicians, (2) specialization, (3) a change in methods of practice. The first approach hardly is practicable. There would have to be more than a 30 per cent increase in the number of practicing physicians if the average work week were to be shortened to forty hours. Specialization is not much better as a solution to the problem. Thus, according to the survey, the only specialities having a work week shorter than fifty hours were EENT, allergy, and dermatology and syphilology. For physicians specializing in surgery or internal medicine, the working hours were almost as long as in general practice, and pediatricians and obstetricians had the longest hours of all! It seems that, if doctors want to lighten their work load without neglecting their patients, they had better look closely at their methods. Too many of them take one look at what they are doing and then begin wishing for a day-stretcher. Perhaps the advice of an efficiency expert is what they need. Certainly wishful thinking is not likely to provide a plan.

—GP, January 1954

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BIRTHS AND DEATHS

Births

Dr. and Mrs. Salvatore I. A. Certo of North Miami announce the birth of a daughter, Salle Ilena, on Feb. 8, 1954.

Dr. and Mrs. John J. Fisher of Jacksonville announce the birth of a son, Frederick Emil Novak, on March 29, 1954.

Dr. and Mrs. Augustus E. Anderson Jr. of Jacksonville announce the birth of a son, Augustus Emmett III, on April 3, 1954.

Dr. and Mrs. Julian M. DuRant of Madison announce the birth of a son, Eugene Keller, on April 5, 1954.

Deaths — Members

Gowdy, Francis A., Fort Pierce ..... April 6, 1954
Swing, Frederick P., Fort Lauderdale ..... May 2, 1954
Vogt, Ferdinand A., Coral Gables ..... May 3, 1954
Ryals, Charles H., Grand Ridge ..... May 3, 1954

Deaths — Other Doctors

Touchton, Walton C., Avon Park ..... April 9, 1954
Bell, Arlis G., Miami Springs ..... April 16, 1954

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, Augustus E. Jr., Jacksonville
Carter, Charles H., Gainesville
Cushman, Robert G., Jacksonville
Hadley, William P., Gainesville
Lovejoy, Elizabeth K., Hialeah
Nelson, Richard A., Jacksonville
Rasmussen-Taxdal, Henry E., Bradenton
Shackleton, John H. Jr., Jacksonville
Storch, Sidney, Jacksonville
Van Nest, Willard A., New Smyrna Beach

Medical Officers Returned

Dr. Robert L. Neil, who entered military service on Oct. 6, 1952, was released from active duty on Oct. 14, 1953, with the rank of first lieutenant, U.S.A.F. (MC). His address is 1216 Cleveland St., Clearwater.

Dr. Robert J. Brown, who entered military service on Nov. 11, 1952, was released from active duty on Feb. 1, 1954, with the rank of lieutenant, U.S.N.R. His address is 3939 Park St., Jacksonville.

STATE NEWS ITEMS

Dr. Walter C. Payne Sr. of Pensacola addressed the Rotary Club of that city at a March luncheon meeting. His talk was a review of the book, "Mystery, Magic and Medicine," by W. D. Howard. The book deals with the early history of medicine.

Dr. Max Gratz of Miami Beach gave the welcoming address at the Second Annual Interim Scientific Meeting of the Phi Lambda Kappa medical fraternity at the Di Lido Hotel in Miami Beach in March. Dr. Gratz is president of the Miami Alumni.

Dr. Marvin G. Flannery of Miami spoke on temperance in all things before the Allied Youth Group of Coral Gables High School on March 25.

Dr. Donald W. Smith of Miami spoke on cancer at a meeting of the Biscayne Woman's Club on March 18.

Dr. Herschel G. Cole of Tampa was named president of the Beach Park Civic Association at a membership meeting in March.

Drs. Alexander H. Bluestone and Bernard Milloff of Hollywood were among a group of physicians and dentists honored at "Doctors' and Dentists' Day at Temple Emanu-El" in March.

Dr. Clarence M. Sharp of Jacksonville, director, Bureau of Tuberculosis Control, Florida State Board of Health, addressed the opening session at the meeting of the Florida Tuberculosis and Health Association in St. Petersburg, April 9-10. His subject was the job which still remains to be done to control tuberculosis in Florida.

Drs. Benjamin A. Wilkinson and George H. Garmany of Tallahassee have returned to their practices after taking courses in heart diseases at the Tulane University of Louisiana School of Medicine in New Orleans.

Dr. Jonathan H. Wood of Jacksonville spoke at the April meeting of the Woman's Auxiliary of St. Catherine's Church. His subject was cancer.

Dr. Oliver F. Deen Jr. of Tampa was principal speaker at the last of a series of talks on weight control nutrition sponsored by the Hillsborough County Nutrition Committee. His subject was "Overweight in Children."

Dr. Wesley W. Wilson of Tampa spoke on the incidence of skin cancer in various skin types at a regular meeting of the Interbay Rotary Club on March 18 and at a meeting of the Palma Ceia Kiwanis Club on April 9.

Dr. James L. Strange of McIntosh was honored on March 14 at a special service in the McIntosh Methodist Church. The occasion marked the completion of 25 years of service to the community. The pastor and members of the church board presented Bibles for use in Dr. Strange's Hospital. The choir for the evening was made up of young people brought into the world by Dr. Strange. A resolution of appreciation was read and presented to the doctor.

Dr. Paul L. Berezney of St. Petersburg has reopened his offices for the practice of general surgery. Dr. Berezney left St. Petersburg in 1949 to study surgery.

Dr. S. Carnes Harvard of Brooksville was elected as a member of the Board of Directors of the "Tampa Touchdown Club" at the annual meeting of the organization in Tampa on March 16.

Dr. Gary E. Turner of Jacksonville spoke on "Psychological Aspects of Losing Weight" before a class on weight reduction sponsored jointly by the Jacksonville Dietetic Association and the Duval County Medical Society.

Dr. Paul J. Coughlin of Tallahassee spoke on maternal and child care at a meeting of the Junior Woman's Club of Tallahassee recently.

Dr. Coughlin also spoke on cancer at a regular luncheon meeting of the Rotary Club on April 21.

Dr. Chester L. Nayfield of Lakeland spoke on "Polio" at a meeting of the Junior Sorosis at the clubhouse on Lake Morton Drive on April 13.

Dr. Leo Grossman of Miami Beach spoke on "Polio Vaccine" before a meeting of the Central Beach P.-T.A. on April 13.

Dr. Alfred S. Massam of Bartow was principal speaker at the March meeting of the Bartow P.-T.A.

Dr. William L. Wright of Sarasota spoke on problems of mental health at a recent meeting of the Woman's Club of that city. The title of his talk was "Everybody is Crazy, But Thee and Me."

Dr. Walter R. Newbern of West Palm Beach spoke on "Loyalty" at the annual banquet of the Good Samaritan Hospital Alumnae Association in compliment to the seven members of the 1954 graduating class of Good Samaritan Hospital.

The University of Florida College of Medicine expects to admit its first class in 1956, Provost Russell S. Poor has announced. The Medical School was given State Legislative approval at the 1953 session and received a $5,000,000 appropriation for the Medical Sciences building.

Dr. Poor, who directed a $96,000 Commonwealth Fund study for planning the Health Center, has previously been announced as Provost for the Center. Contract for the foundation of the Medical Sciences building is expected to be let in the near future, with actual construction expected to begin by midsummer.

Dr. George T. Harrell, former head professor in charge of research at the Bowman-Gray School of Medicine at Wake Forrest, has been named Dean of the College of Medicine.

Dr. Thomas H. Lipscomb of Jacksonville was moderator of an X-ray conference held in conjunction with the annual meeting of the Florida Tuberculosis and Health Association in St. Petersburg in April.

Drs. James B. Leonard, Clearwater; Wray D. Storey, Tampa; and Millard B. White, Sarasota, spoke at the spring meeting of the Florida Division of the American Society of Medical Technologist at Redington Beach, April 3 and 4. Dr. Leonard spoke on "Changing Concepts of Disease;" Dr. Storey, "Laboratory Procedures of Value in Certain Mosquito-borne Diseases;" and Dr. White, "Recent Advances in Laboratory Technology."

Doctors throughout the nation were recognized on Doctors' Day, March 30. The observance of this day was started in 1933 by the Barrow County (Georgia) Medical Auxiliary upon the suggestion of Eudora Brown Almond, wife of the late Dr. C. B. Almond. March 30 was chosen because that was the date that Crawford W. Long first used ether anesthesia in surgery. Now this day is observed in nearly all the states of the Union.

The day was celebrated in various ways in Florida counties. In Bay County, doctors and dentists from Panama City, Tyndall AFB and the United States Navy Mine Countermeasures Station were honored at a hard times dinner party given for them by the Woman's Auxiliary at the St. Andrew Yacht Club. The Woman's Auxiliary to the Brevard County Medical Society entertained with a ranch style supper at the home of Dr. and Mrs. Arthur C. Tedford. A barn dance was held by the Woman's Auxiliary to the Broward County Medical Association at the Lions Club in Fort Lauderdale. On their morning hospital rounds, doctors received boutonnieres of red carnations from the Auxiliary. In Hollywood, churches of all faiths held a special prayer period for the medical profession and placed red carnations on the altars in memory of deceased doctors of the congregations.

Members of the Escambia County Woman's Auxiliary also pinned red carnations on their husbands, as did the Orange County Auxiliary. Quincy doctors were honored by their wives with a buffet supper at the home of Dr. and Mrs. Taylor W. Griffin. The Woman's Auxiliary of the Gadsden County Hospital presented each doctor with a red carnation as he came to the hospital during the day. Members of the Jackson-Calhoun County Medical Society were entertained at a dinner given in Marianna by the Woman's Auxiliary to that Society. In Pinellas County, St. Petersburg doctors were greeted on their morning hospital rounds by members of the hospitals' auxiliaries who presented each doctor with a carnation in observance of the day. The Woman's Auxiliary to the Sarasota County Medical Society entertained doctors of that county with a dinner party at the home of Dr. and Mrs. Reaves A. Wilson. A dinner was held at the Mayfair Inn in Sanford in honor of Seminole County doctors. Dr. and Mrs. Arthur Schwartz and Dr. and Mrs. Joel Mendelson gave a party for members of the Volusia County Medical Society and their wives.

Dade County doctors entertained with a Doctors' Day Dinner at the Coral Gables Country Club on April 23. Dr. and Mrs. R. Sam Mosley of Coral Gables and Dr. and Mrs. Donald F. Marion of Miami entertained doctors and their wives preceding the dinner.

Dr. Sherman R. Kaplan of Miami Beach was among the physicians from throughout the country who spoke at the meeting of the Florida Society of Medical Technologists meeting concurrently with the southeastern branch of the Society of American Bacteriologists in Jacksonville in April.

Dr. Louis M. Orr of Orlando spoke on "Government Medicine, VA Style," at the Fourth Annual County Medical Society Officers Conference of the Kentucky State Medical Association, April 15, in Lexington, Ky.

Dr. Paul S. Roland of Miami Beach has been appointed provost of the Miami Army Reserve School. Dr. Roland holds the rank of lieutenant colonel.

Dr. William E. Bippus of West Palm Beach spoke on cancer at a meeting of the Rotary Club of Fort Pierce on March 29.

Dr. Joseph F. Keeley Jr. of Miami spoke on arthritis at a luncheon sponsored by the women's membership committee of the South Florida Chapter of the Arthritis and Rheumatism Foundation on April 1 at the Miami Woman's Club.

Dr. Leonard G. Rowntree of Miami Beach recently received an American Legion citation for distinguished service. This citation has been presented to only one other medical doctor in the last ten years.

Dr. Joel V. McCall Jr. of Daytona Beach was commentator at the showing of a film on cancer entitled, "A Doctor Speaks His Mind," at the North Ridgewood P.-T.A. meeting on April 1.

Dr. Robert E. Rothermel of St. Petersburg was in charge of local arrangements for the annual convention of the Southern Branch of the American Public Health Association in St. Petersburg, April 21-24. The Pinellas County Health Department was host at the meeting. Dr. Rothermel is County Health Officer.

Dr. Bennett J. LaCour of Daytona Beach spoke on "Cancer in Children" at a luncheon meeting of the Palmette Department on April 1.

Dr. Hillard W. Willis of Coral Gables participated on the "answer team" at the four hour study course sponsored recently by the Dade County P.-T.A. Council.

The Third Biennial Cardiovascular Seminar and the Annual Convention of the Florida Heart Association was held April 29-May 1 at the Delano Hotel, Miami Beach. The Seminar, which was sponsored jointly by the Heart Association of Greater Miami, the Florida Heart Association and the Florida State Board of Health, followed the Annual Convention of the Florida Medical Association in Hollywood.

The Fourth Annual Postgraduate Seminar of the Mount Sinai Hospital of Greater Miami was held May 21-23 at the Delano Hotel, Miami Beach. The Seminar was conducted by a group of nine lecturers of national distinction.

Drs. Robert B. Harkness and Harry S. Howell of Lake City attended the Atlanta Graduate Medical Assembly in February.

Dr. Warren A. Brooks of Orlando was guest speaker at the annual meeting of the St. Lucie County Tuberculosis and Health Association on April 2. His subject was "Treatment of Tuberculosis."

Dr. Karl B. Hanson of Jacksonville took a short course under the auspices of the American College of Physicians at Presbyterian Hospital in New York in March.

Dr. E. Frank McCall of Jacksonville gave a paper on "The Cause of Prematurity and Its Management" at a sectional meeting of the American College of Obstetrics and Gynecology in Washington recently.

Dr. Jack A. Rudolph of Miami Beach has been appointed consultant in allergy at the Veterans Administration Regional Office, Miami. Dr. Rudolph recently visited the allergy clinics at Northwestern, Wesley Memorial and Passavant Hospitals in Chicago.

The American Proctologic Society is holding its Fifty-third Annual Meeting at the Hotel Statler in Los Angeles, June 2-5, 1954. Wednesday, June 2, is being devoted to didactic instruction in the basic sciences by instructors and professors eminent in their several fields. In addition to numerous scientific papers on proctologic subjects, symposia on anorectal and colonic surgery are being held.

The Florida Blue Cross and Blue Shield Plans are presenting a new television program, "Janet Dean, Registered Nurse," every Tuesday at 7:00 p.m. over station WMBR-TV, Channel 4, Jacksonville. Starring motion picture star, Ella Raines, each weekly half-hour program tells the complete story of a medical problem taken from authentic case histories which have been adapted for TV. The program has the endorsement and approval of the American Nurses' Association and the National League of Nursing.

Dr. Richard G. Skinner Jr. of Jacksonville has been elected president of the Northeast Florida Association for Mental Health.

Dr. Curtis D. Benton Jr. of Fort Lauderdale will be among physicians of the United States presenting scientific papers at the Pan American Association of Ophthalmology Third Interim Congress, June 17-21, in Sao Paulo, Brazil.

Drs. Lee E. Bransford Jr., Hugh A. Carithers, Charles F. McCrory, Shaler Richardson and Richard G. Skinner Jr. of Jacksonville took part in a four day institute for parents of visually handicapped children held in Jacksonville in March and April.

Dr. Robert C. Welsh of Miami has returned to his practice after attending the corneal transplant course of Dr. Townley Paton and Dr. Herbert Katzin at the Manhattan Eye and Ear Infirmary, New York.

Dr. Ashbel C. Williams of Jacksonville was guest speaker at a meeting of the Junior Woman's Club of South Jacksonville in March. His subject was "Cancer."

Dr. John J. Fisher of Jacksonville talked on cancer at the Pickett Home Demonstration Club in April.

Dr. William C. Thomas Sr. of Gainesville was presented with a Certificate of Distinction at a surprise party given in his honor at the First Baptist Church on April 15. Dr. Thomas, who went to Gainesville 30 years ago to begin his medical practice, was presented the certificate by Milton Brownlee, president of the Chamber of Commerce. An address by Mayor-Commissioner Joe C. Wise denoted the many contributions made to the community by Dr. Thomas. Several other addresses and poems were given, all paying tribute to the doctor.

Dr. Louis M. Orr of Orlando took part in a symposium on "Carcinoma of the Prostate" at the April meeting of the American Urological Association, Southeastern Section, in Palm Beach.

Dr. Walter R. Newbern of West Palm Beach spoke on cancer at a meeting of the Civitan Club of that city on April 15.

Dr. David Sloane, formerly of Orlando, announces the opening of his offices at 1231 Lakeland Hills Blvd., Lakeland. His practice is limited to orthopedic surgery.

Dr. J. Basil Hall of Mount Dora spoke on "Rabies Control in a Rural County" at the recent Southeastern United States Rabies Conference in Tampa.

Dr. Hall was the guest speaker at the regular luncheon meeting of the Mount Dora Kiwanis Club on April 7. He spoke on public health and longevity.

Dr. Charles F. McCrory of Jacksonville took part in April in a radio panel discussion on problems of the eye.

Dr. Edward R. Annis of Miami discussed the polio vaccine campaign and what it aims to accomplish at a meeting of the Miami Shores P.-T.A. on April 13.

Dr. Leroy H. Oetjen of Leesburg has been reelected president of the Leesburg Health Council.

Dr. H. Milton Rogers of St. Petersburg and Dr. Alvin E. Murphy of West Palm Beach were moderators at a public panel discussion on heart disease held in Miami in conjunction with the Third Cardiovascular Seminar in April.

Blue Cross and Blue Shield Plans across the nation embarked on their first big national program of public education in April. Plans call for nine Blue Cross messages in Life, eight in the Saturday Evening Post, and eight in Look. The Blue Shield message will appear five times in Life, five times in the Post, and four times in Look. Combined circulation of the three magazines for any one issue is 71 million.

Dr. Irwin S. Leinbach of St. Petersburg was appointed a Delegate from the United States Section of the International College of Surgeons to attend the All-European Congress in Torino, Italy, June 1-3. Dr. Leinbach also was guest lecturer in orthopedic surgery at the University of Goettingen, Germany, and attended orthopedic clinics in Berlin, Hamburg, Cologne and Aachen, Germany.

Dr. Leinbach spoke before the Surgical-Orthopedic Section of the Croatian Medical Association on May 6 in Zagreb, Yugoslavia. His subject was the treatment of fractures of long bones and hip joint.

The second annual meeting of the Inter-Society Cytology Council will be held in Boston, November 12 and 13, at the Statler Hotel. Registration is open to everyone interested in Cytology. Registration fee for physicians is $5.00; for cytologic-technologists, technicians and others, $2.00. Medical students, internes and residents will be admitted without charge. For additional information contact the Secretary-Treasurer, Inter-Society Cytology Council, 634 North Grand Blvd., St. Louis, Mo.

Those having material to present are invited to submit three copies of the title and an informative abstract of not more than 200 words to Dr. John B. Graham, Chairman of the Program Committee, 32 Fruit St., Boston, before July 15.

Dr. Henry F. Keiber of Winter Haven was among the guests of the Lions Club at their meeting on April 16. Dr. Keiber works with the Club on their sight conservation program.

Dr. John V. McMackin of Miami has returned to his practice after attending a course for eye physicians in Pittsburgh.

COMPONENT SOCIETY NOTES

Dade

At the regular meeting of the Dade County Medical Association on May 4, Dr. George F. Schmitt Jr. presented a paper on "Milliequivalent in Clinical Medicine," and Dr. Thomas S. Gowin presented a paper on "Presentation of Cases Demonstrating the Use of Milliequivalent." A special call meeting of the Association was held on May 14 at which time the speaker was Dr. George T. Harrell, Dean of Medicine, University of Florida.

Duval

At the meeting of the Duval County Medical Society on May 4, Dr. Joseph A. J. Farrington spoke on "Reactions to Antibiotics with Special Reference to Penicillin."

Hillsborough

At the regular meeting of the Hillsborough County Medical Association on May 4, Dr. William D. Davis of the Oschner Clinic spoke on "Management of Cirrhosis and Hepatitis."

Lake

The regular monthly meeting of the Lake County Medical Society was held on April 7 at the Howey Country Club. Dr. Francis T. Holland of Tallahassee was guest speaker. His subject was the rural health program.

The regular monthly meeting of the Lake County Medical Society on May 5 was held at the Fountain Inn, Eustis. Dr. Jack H. Bowen of Jacksonville, assisted by Dr. George M. Stubbs, also of Jacksonville, spoke on premalignant and malignant lesions.

Leon-Gadsden-Liberty-Wakulla-Jefferson

A panel discussion on medical-legal relationships was held at the meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society on April 15. The panel was made up of four members of the Tallahassee Bar Association. Dr. Merritt R. Clements was program chairman and panel moderator.

Marion

At the regular monthly meeting of the Marion County Medical Society on April 20, Dr. George T. Harrell, Dean of the University of Florida School of Medicine, was guest speaker. His subject was "Plans for the University of Florida Medical School and the Medical Center."

Palm Beach

The Palm Beach County Medical Society has paid 100 per cent of its state dues for 1954.

The Palm Beach County Medical Society has endorsed the position of the National Foundation for Infantile Paralysis, the U. S. Public Health Service and the Palm Beach County Health Dept. in approving the proposed vaccination of school children against infantile paralysis.

Pinellas

At the regular monthly meeting of the Pinellas County Medical Society on May 3, Major George E. Drury, USAF (MC), Chief of Aeromedical Services at MacDill Field, spoke on "Aviation Medicine."

Volusia

Dr. Orin R. Yost of Ormond Beach spoke on "The Modern Management of Psychiatric Problems" at a meeting of the Volusia County Medical Society on April 13 in Daytona Beach. Dr. Yost is the author of the book "What You Should Know About Mental Illness" published recently.

A three-day special clinic was presented in April by the Society for the Bethune-Cookman College. Dr. Henry E. Bartley of Daytona Beach was moderator. Participants and their topics were: Dr. Frank A. Cica, Holly Hill, "Patent Medicines;" Wally Reichenberg, psychologist, Columbia University, New York City, "Mental Health;" Drs. Cleland D. Cochrane, Daytona Beach, "Pulmonary Tuberculosis;" Morris B. Seltzer, Daytona Beach, "Hypertension;" and Achille A. Monaco, Daytona Beach, "Cancer." Summarizing these topics was Dr. Texas A. Adams, college physician.

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OBITUARIES

Henry Hanson

Dr. Henry Hanson of Jacksonville died at his home on Feb. 13, 1954, following a brief illness. He was 76 years of age.

Born in Glenwood, S. D., on July 4, 1877, Dr. Hanson received his academic training in his native state. He was awarded the A.B. degree in 1902 and the M.A. degree in 1904 by the University of South Dakota. His undergraduate studies in medicine were completed in 1908, when he received the M.D. degree from the Johns Hopkins University School of Medicine. He was a member of the Phi Beta Kappa honorary fraternity.

After serving on the faculty of the University of South Dakota and of Marquette University in several positions in the field of pathology and bacteriology, Dr. Hanson became Director of Laboratories for the Florida State Board of Health in 1909. He continued in that post until 1916, when he entered the private practice of medicine in Jacksonville as a clinical pathologist. For a time in 1918-1919, he served as a medical officer in the United States Army, with the rank of major, and was assigned to sanitation work in the Canal Zone.

In 1919 Dr. Hanson was recalled to the field of civilian public health, and accepted the position of Assistant Chief Health Officer with the Panama Canal Zone Health Department. His intense interest in tropical diseases took him to Peru in 1920, where he served the Peruvian Government as Director of Yellow Fever Control until 1922. After this assignment his authoritative knowledge and accomplishments in the field of tropical diseases led to his affiliation with the Rockefeller Foundation from 1923 to 1927. During this period his duties took him to West Africa for 18 months, where he worked with the West African Yellow Fever Commission.

Dr. Hanson reaffiliated with the Florida State Board of Health in 1928 and in 1929 for the first time became State Health Officer, a position which he filled until 1936. He then returned to various assignments in Latin America, including extensive work with the Pan-American Sanitary Bureau, and special services to the governments of most of the South American countries. He was appointed State Health Officer of Florida again in 1942, serving this time until his retirement in 1945.

During his long and fruitful career, Dr. Hanson published many papers on such subjects as heart disease, rabies, pellagra, malaria and yellow fever. For his outstanding accomplishments he was signally honored and decorated by the governments of Peru, Paraguay, Ecuador and Cuba.

Dr. Hanson held membership in many professional organizations. He was a member of the Duval County Medical Society and served as its president in 1916. For 29 years he was a member of the Florida Medical Association and for many years was affiliated with the American Medical Association and the Southern Medical Association. Founder and first president of the Florida Public Health Association, he was active also in the American Public Health Association. In addition, he was a member of the Isthmian Canal Zone Medical Association, serving as president in 1919, a charter member of the American Academy of Tropical Medicine, and a member of the American Society of Tropical Medicine, the National Malaria Commission, and the American Society of Parasitologists.

Dr. Hanson was a Protestant, a Scottish Rite Mason, thirty-second degree, and a Shriner with affiliation in the Canal Zone.

Surviving are the widow, Mrs. Margaret Hanson, of Jacksonville; two sons, Dr. Karl B. Hanson, of Jacksonville, and Dr. Virgil Hanson, of Riverside, Calif.; one daughter, Mrs. Harold Mahn, of Cleveland, Ohio; two sisters, Mrs. Joe Hedeen, of Sioux City, Iowa, and Miss Clara Hanson, of Oklahoma City, Okla.; one brother, the Reverend Louis Valentine, of Los Angeles, Calif.; and six grandchildren.

Samuel Benjamin Strong

Dr. Samuel Benjamin Strong died on Feb. 6, 1954, in Palatka. He was 77 years of age.

Dr. Strong was born in Bloomingdale, Mich., on Dec. 11, 1876. He was graduated from the Bennett College of Eclectic Medicine and Surgery in 1906 and subsequently served an internship and a residency in the Cook County Hospital in Chicago.

(Continued on page 954)

Amebiasis[1] a "Poorly Reported" Disease

Until serious complications arise, amebiasis may pass unrecognized and patients receive only symptomatic treatment.

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence[1] are incomplete because its manifestations are not commonly recognized and consequently not reported.

"*Vague symptoms*[2] *referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy.*"

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating[3] even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis[1] is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin[4] finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebacide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



Endamoeba histolytica (*trophozoite*).

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. *42*:1 (Jan.) 1952.

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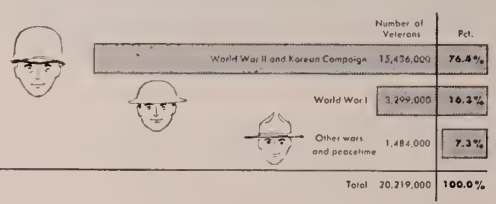
He then engaged in the private practice of medicine in Barrabow, Wis., for a year and a half before entering the practice of medicine with emphasis on surgery in Havana, Cuba. He was licensed to practice medicine in Florida in 1909 and became a member of the Florida Medical Association in 1912. Two years later he became an active member of the Putnam County Medical Society. Later, he volunteered for service in the United States Army and served on the surgical staff of the Station Hospital at Fort Oglethorpe, Ga., for the duration of World War I. He was subsequently discharged with the rank of captain.

Upon completion of his military service, Dr. Strong re-entered the private practice of medicine and surgery in Havana, Cuba, where he continued to practice until 1949. At that time, he returned to the United States and located in Florida, practicing for short periods in Port St. Joe, Palatka and Hastings.

In Viewing the VA Medical Program . . .

analysis of veteran population

PERIOD OF SERVICE



Taxpayers should note that as veterans grow older they require more frequent and increasingly longer periods of hospitalization. World War I patients are now hospitalized twice as long, on the average, as World War II patients with similar disabilities. World War II veterans, relatively young and comprising 76% of the total veteran population, present a costly long term responsibility to U. S. taxpayers. The medical profession recommends medical care through the VA for only those veterans with service-incurred disabilities and temporarily for those with tuberculosis or neuropsychiatric conditions of non-service-connected origin.

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Twenty-Seventh Annual Meeting Largest in History

The twenty-seventh annual meeting of the Woman's Auxiliary to the Florida Medical Association marked the largest attendance of any other meeting ever held. Reports for 1953-54 which were printed shortened the meeting by a great deal of time and brought forth much enthusiasm. They showed that the Auxiliary had gained in membership to a total of 1,455 members, 99 more than the year before. The State Auxiliary has 21 component county auxiliaries represented and seven counties with members at large where no organized auxiliaries have yet been effected.

Much interest was shown in the state project of last year, the equipping of a two-chair beauty shop for the new woman's receiving hospital at the Florida State Hospital at Chattahoochee; and the report showed that a beautician has been employed full time and patients are helping her. In the three weeks after opening, the beauty shop had given 186 haircuts, 155 shampoos and sets, 74 manicures, 14 eyebrow arches, 80 permanent

waves, 80 dandruff treatments and 14 color rinses. All were proud and pleased that we, through our efforts, had brought better morale to the patients in the institution.

All component county auxiliaries participated in nurse recruitment; future nurses clubs were continued and new ones established; teas were given for nurses in training; films on nursing were shown and career days in high schools were covered for careers in nursing. This project continues to grow by leaps and bounds. In program and public relations the auxiliaries have continued to inform themselves, and then to inform others of health needs, health education and community participation. The emphasis has been on every doctor's wife being a public relations agent for her husband and for organized medicine.

Three scholarships of the loan type were given as matching funds to county auxiliaries for deserving students wanting to attend nursing school.

Positive health education and positive public relations for medicine and for our county medical societies were heavily supported through the obtaining of almost 2,000 credits in the work of promotion of Today's Health, authentic and factual health magazine published by the American Medical Association for the public. This is the second year that Florida has so well supported this program that they have obtained more than 100 per cent of their quota, the quota being based on the membership of 1,356 last year.

All in all, though all progress cannot be listed here, everyone went away from the Convention feeling that great progress and advances had been made during this year and that the Woman's Auxiliary to the Florida Medical Association has become adult and a real asset to the community, state and the medical profession. Dr. Edward Jelks, guest speaker at the luncheon, emphasized the value of the Auxiliary in public relations and welcomed its support and work. The Auxiliary greatly appreciated his giving time to come and speak to us.

Conventions are not without fun, and this year was no exception. The choral group of the Orange County Auxiliary which sang about how they "loved anesthesiology because it was so easy to say," the many unplanned laughs of the Convention and the fun and happiness of seeing old friends and making new all gave impetus and happiness to a wonderful Convention.



Mrs. Richard F. Stover
President, Woman's Auxiliary

If you weren't there you don't know what a wonderful time you missed, and if you were there, you can now sit back and remember all the nice things that happened and be thankful you went.

We are proud of our accomplishments and are looking forward to another fine year for 1954-55, for it would have to be fine with the wonderful members and the workers that we have throughout Florida.

Mrs. Richard F. Stover, President

Twenty-Eighth Annual Meeting

Woman's Auxiliary to

The Florida Medical Association

St. Petersburg, April 3-6, 1955

BOOKS RECEIVED

Doctor at Sea. By Richard Gordon. Pp. 191. Price, $3. New York, Harcourt, Brace and Company, 1954.

Following in the wake of "Doctor in the House," this second book by a young British physician-humorist came from the press late in January. With a quick eye for the ridiculous and an incomparable knack for vivid scenes, Richard Gordon recounts the voyage of the S. S. Lotus from Liverpool to South American ports and return through the eyes of the ship's doctor, who had never been to sea before. He introduces the reader to "the zaniest crew that ever kept an accident-prone hooker afloat" and says of this humorous boatload of H. M.'s first class, able-bodied seamen: "Sailors are of the few remaining people who make their way in companies across the unsignposted face of the world. Their sense of values is therefore unblunted; they look on their existence as a long uproarious joke relieved by not unentertaining interludes of necessary tragedy. I thought them the last of the Elizabethans."

The Allergic Child. By Harry Swartz, M.D. Pp. 297. Price, $3.95. New York, Coward-McCann, Inc., 1954.

This up-to-the-minute book explains the general problem of allergy in children, what allergy is, how it shows itself. It guides the parent in discovering early allergic symptoms and will help parents who themselves are allergic. It is the first book on this subject directed solely to the layman, the audience for the book being literally "the parent in the street." The author points out that there are 40 million children in this country under 14 years of age. Of these, half have allergies of one degree or another. Ten million of this latter group may suffer permanent harm if their allergies are not taken care of right away. This book shows parents how to recognize allergies and impresses upon them the necessity for early and prompt treatment.

It is explained here that allergies are found in emotionally normal children — that they are not solely the misfortune of the neurotic child — and that permanent emotional and mental harm can result from lack of attention. There is a chapter on nutrition which points out that a nutritional defect can be the cause of an allergy. The book can be divided into two categories: Child Care and Medical Information. Dr. Swartz maintains that if something is done early to help the allergic child, there is an excellent chance that relief can be effected, but that chance diminishes literally as each month of neglect goes by. And the sooner the child is under medical care, less time and money, in the long run, are spent. Since the young child's potentialities are still untapped, his emotional and behavior pattern not yet set, an allergy can cause havoc. There is an appendix with a list of substitute foods and also the composition of common foods listed.

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The Book of Health, A Medical Encyclopedia for Everyone. Compiled and edited by Randolph Lee Clark Jr., B.S., M.D., M.Sc. (Surgery), and Russell W. Cumley, B.A., M.A., Ph.D. Pp. 836. Illus. 1,400. Price, $12.50. New York, Elsevier Press Inc., 1953.

This unique book tells what 242 doctors believe the laity should know about medicine. It presents a body of authoritative medical information never before available to the layman. In addition, it is an acceptable source of information for the student of physiology and hygiene, and for those preparing themselves for the study of medicine, nursing, dentistry and technology. It should also provide valuable orientation for the science writer, hospital administrator, medical secretary, medical librarian, medical social worker, and the many other auxiliary workers in the medical field.

Why has such a large group of outstanding physicians, dentists, pharmacologists, nurses, research scientists and other technical experts given so much time, thought and energy to the preparation of a book of this type? The answer is: Medicine is no longer a secret science. Every newspaper and magazine published information and stories about progress in medicine. Sometimes, this information is premature or unreliable; often it raises false hopes. Consequently, since so much misinformation is being read by the public, the editors of this timely volume undertook to assemble a group of experts, who would assist them in giving the public the clearest and most complete medical information available. The monumental work which resulted is not a "home doctor book." It does not tell the reader how to treat a disease, but enables him to understand what can be done by medical science to maintain at the highest possible standard his own health, and the health of his family and community.

In these pages there is unfolded the story of the body's development, the changes it undergoes from birth until death, and the diseases which may attack it. Interwoven, is the story of the great contributions to medical knowledge from the dawn of antiquity to the present day. Historically, the editors believe the book to be unique in that many of today's physicians and scientists destined for future renown have edited the accounts of their contributions to medicine. Among the contributors are two Florida physicians, Dr. Jere W. Annis and Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Florida.

The editors have had broad experience as delineators of medical fact and have demonstrated abundantly that medical reading matter can be lively, entertaining — even, at times, inspirational — and still maintain a high standard of scientific integrity. In this crowning endeavor, they have brought this principle to bear in the presentation of medical material for the layman. They have been ably assisted not only by distinguished physicians, dentists and medical research scientists who are authorities in their particular fields but also by 30 professional medical writers who have interpreted existing medical fact in a literary style of high quality, and by a staff of artists and photographers who have embellished the book with some 1,400 illustrations. This comprehensive work is indeed a medical encyclopedia for everyone, a publication that fills a real need and one about which physicians will wish to be informed.

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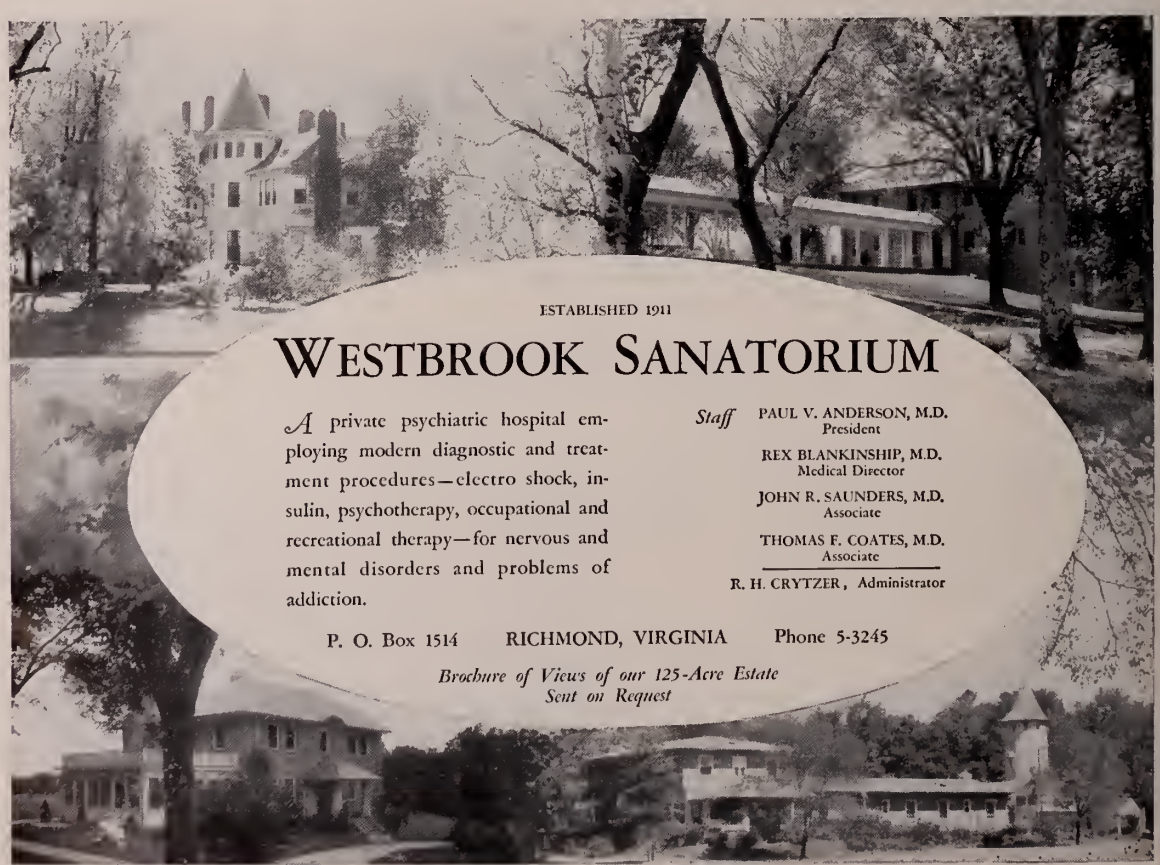
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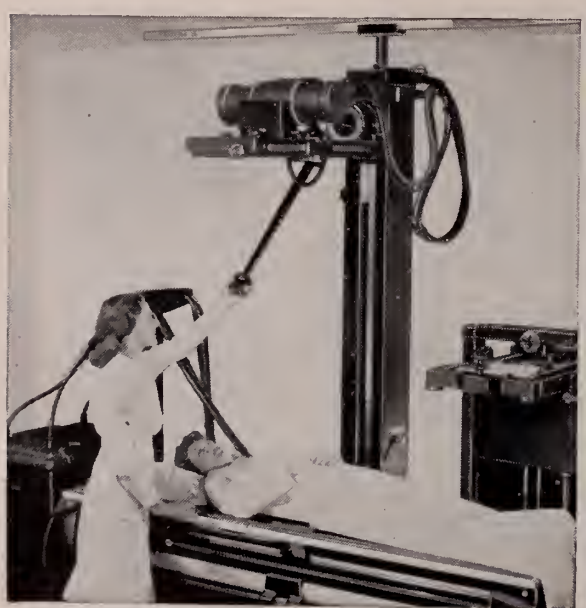
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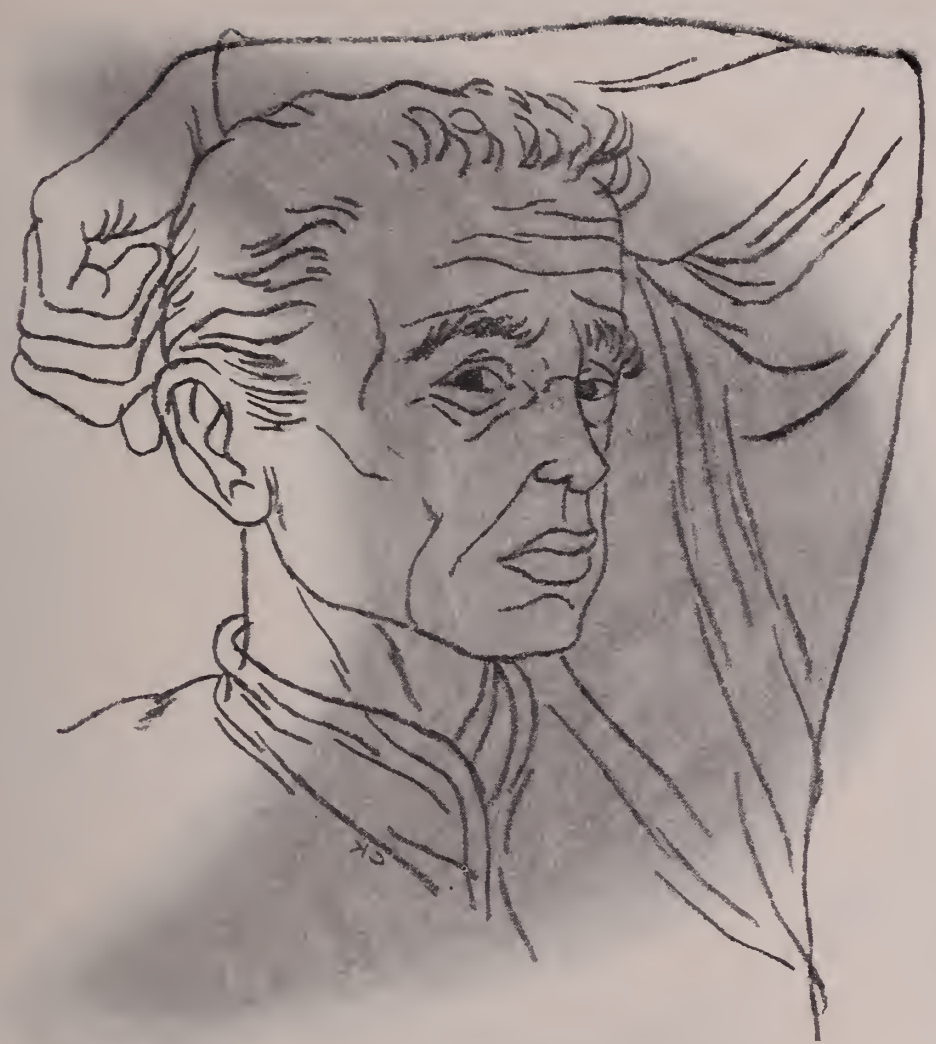
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1. Gurdjian, E. S., and Webster, J. E., Amer. J. of Surgery, 63:236, 1944.

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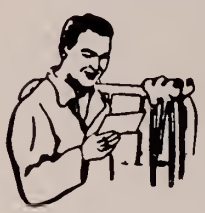
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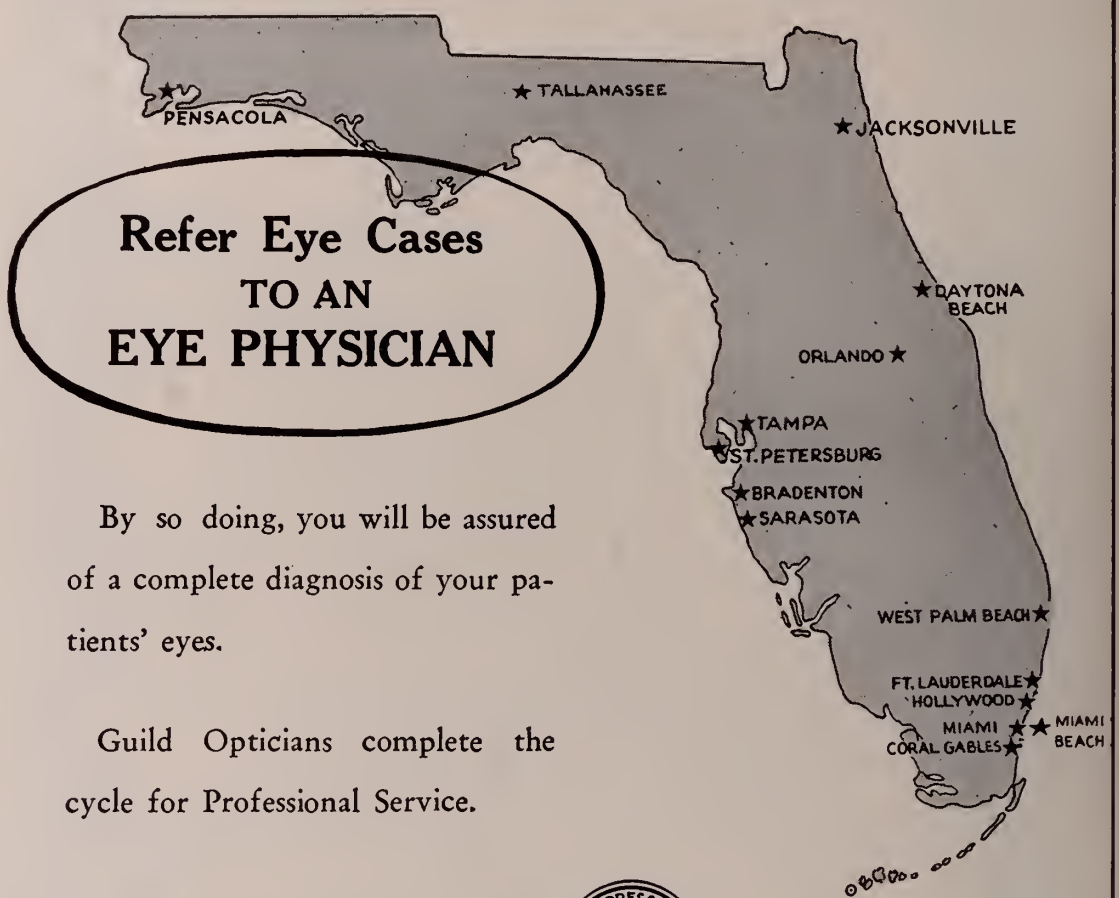
They have shown that wine in judicious quantities can stimulate the lax and achlorhydric stomach of the elderly, assist in providing a more adequate fluid intake, and improve elimination by enhancing the important gastrocolic reflex.

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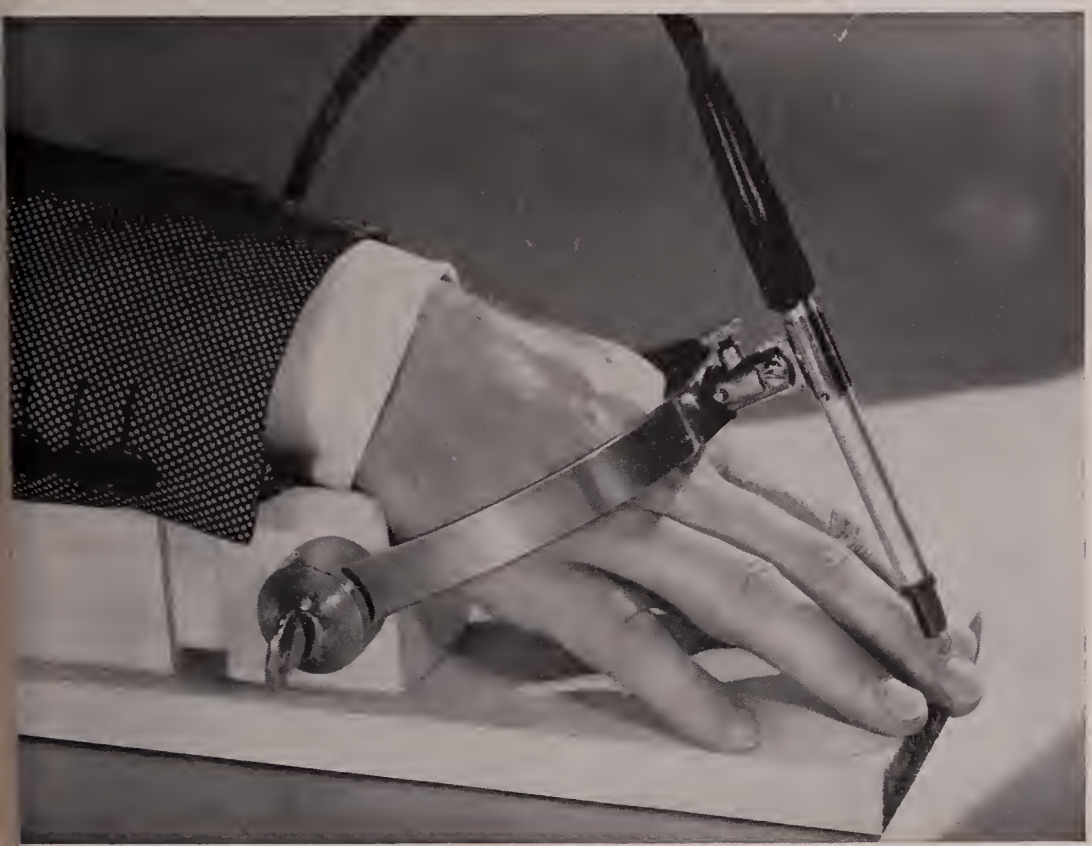
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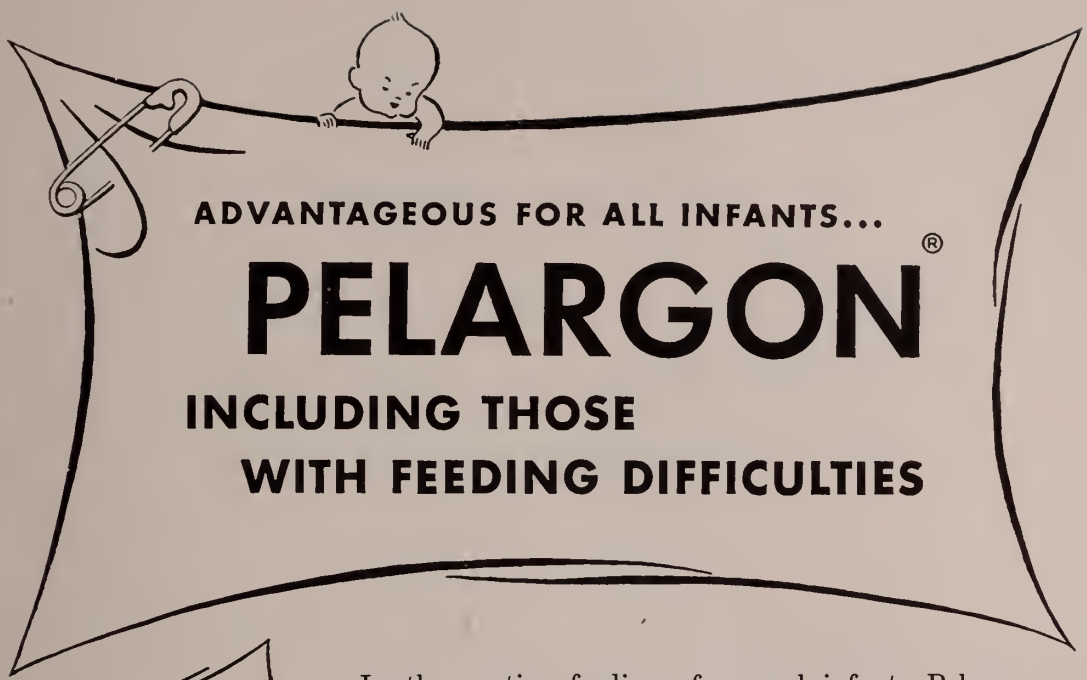
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lorida Medical Districts	Francis H. Langley, St. Petersburg	Council Chairman	
A-Northwest	William H. Hixon, Pensacola	George S. Palmer, Tallahassee	Marianna, Oct. 11, '54
B-Northeast	Henry J. Babers Jr., Gainesville	Thomas C. Kenaston, Cocoa	Sanford, Oct. 13, '54
C-Southwest	James R. Boulware Jr., Lakeland	Clyde O. Anderson, St. Petersburg	Sarasota, Oct. 15, '54
D-Southeast	James R. Sory, West Palm Beach	Russell B. Carson, Ft. Lauderdale	Vero Beach, Oct. 14, '54
orida Specialty Societies			
:ademy of General Practice	Leonard L. Weil, Miami Beach	Leon S. Eisenman, Hialeah	St. Petersburg, Apr. 3, '55
lergy Society	Solomon D. Klotz, Orlando	Edwin P. Preston, Miami	" "
nesthesiologists, Soc. of	R. Gaylord Lewis, West Palm Beach	Harry E. Bierley, West Palm Beach	" "
nest Phys., Am. Coll., Fla. Chap.	DeWitt C. Daughtry, Miami	Jack Reiss, Coral Gables	" "
:rm. and Syph., Soc. of			" "
:alth Officers' Society	Thomas E. Morgan, Jacksonville	Lorenzo L. Parks, Jacksonville	" "
dustrial and Railway Surgeons	Plumer J. Manson, Miami	John H. Mitchell, Jacksonville	" "
urology & Psychiatry	Sullivan G. Bedell, Jacksonville	Roger E. Phillips, Orlando	" "
. and Gynec. Society	Harold G. Nix,Tampa	Reuben B. Chrisman Jr., Miami	" "
phthal. & Otol., Soc. of	G. Tayloe Gwathmey, Orlando	Carl S. McLemore, Orlando	" "
thopedic Society	John F. Lovejoy, Jacksonville	Newton C. McCollough, Orlando	" "
thologists, Society of	Millard B. White, Sarasota	James B. Leonard, Tampa	" "
diatric Society	C. Jennings Derrick, W. Palm Bch	Wesley S. Nock, Coral Gables	
ctologic Society	Claude G. Mentzer, Miami	George Williams Jr., Miami	St. Petersburg, Apr. 3, '55
diological Society	A. Judson Graves, Jacksonville	James T. Shelden, Lakeland	" "
rgeons, Am. Coll., Fla. Chapter	Frederick J. Waas, Jacksonville	C. Frank Chunn, Tampa	" "
ological Society	Linus W. Hewit, Tampa	Frank J. Pyle, Orlando	" "
rida—			
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Blue Shield of Florida, Inc.	David R. Murphey Jr., Tampa	Jack O. W. Rash, Miami	
Cancer Council	Ashbel C. Williams, Jacksonville	Lorenzo L. Parks, Jacksonville	St. Petersburg, Apr. 3, '55
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Dental Society, State	Robt. Thoburn, D.D.S., Daytona Bch	J. E. Edwards, D.D.S., Coral Gables	Jacksonville, Apr. 23-25, '55
Heart Association	Alvin E. Murphy, Palm Beach	Daniel R. Usdin, Jacksonville	
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Medical Examining Board	Amsie H. Lisenby, Panama City	Homer L. Pearson Jr., Miami	Jacksonville, June 27-29, '54
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Nurses Association, State	Mrs. Bertha King, Tampa	Mrs. Idalyn Lawthon, Tampa	November '54
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uberculosis & Health Assn.	Judge Ernest E. Mason, Pensacola	Mrs. L. C. Conant, Fort Myers	
Woman's Auxiliary	Mrs. Richard F. Stover, Miami	Mrs. S. J. Wilson, Ft. Lauderdale	St. Petersburg, Apr. 3, '55
erican Medical Association	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	San Francisco, June 21-25, '54
.M.A. Clinical Session	Edward J. McCormick, Toledo, O.	Geo. F. Lull, Chicago	Miami, Nov. 29-Dec. 2, '54
thern Medical Association	Alphonse McMahon, St. Louis	Mr. C. P. Loranz, Birmingham	St. Louis, Nov. 8-11, '54
ama Medical Association	J. M. Donald, Birmingham	Douglas L. Cannon, Montgomery	Montgomery, Apr. 21-23, '55
rgia, Medical Assn. of	Peter B. Wright, Augusta	David Henry Poer, Atlanta	Augusta, May 1-4, '55
. Hospital Conference	Mr. John W. Gill, Vicksburg, Miss.	Mr. Pat Groner, Pensacola	Atlanta, Apr. 20-22, '55
theastern Allergy Assn.	W. L. Rucks, Memphis, Tenn.	Kath. B. MacInnis, Columbia, S. C.	
theastern, Am. Urological Assn.	Sam L. Raines, Memphis, Tenn.	Robert F. Sharp, New Orleans	New Orleans Mar. 20-23, '55
theastern Surgical Congress	J. Duffy Hancock, Louisville, Ky.	B. T. Beasley, Atlanta	Atlanta, Mar. 7-10, '55
f Coast Clinical Society	Jas. N. Lockard, Pascagoula, Miss.	F. C. Minkler, Pascagoula, Miss.	Edgewater Park, Miss., Oct. 21-22,

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Proceedings of

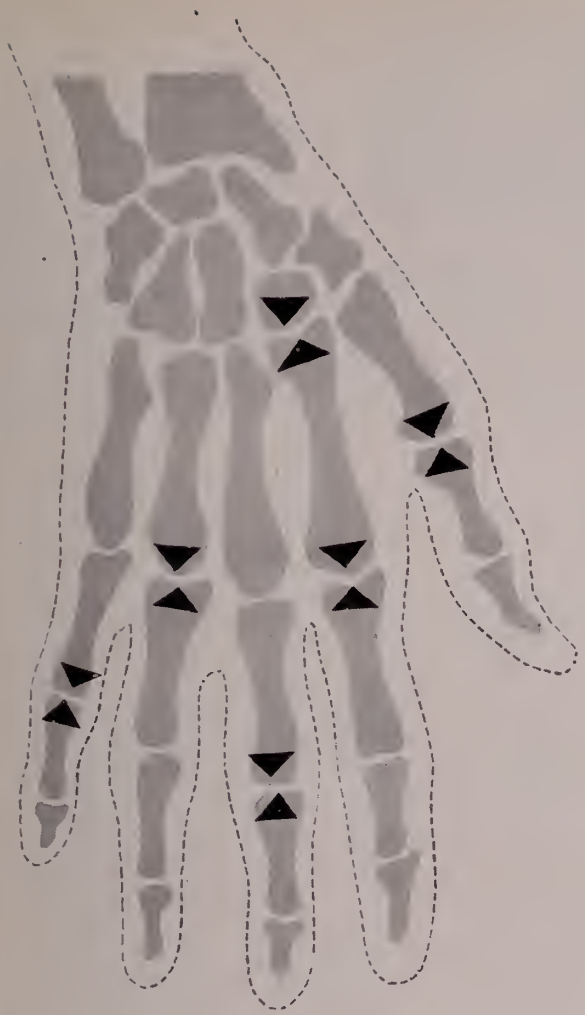
Eightieth Annual Meeting

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County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Henry H. Graham, Gainesville	Glenn O. Summerlin, Gainesville	2nd Tues.	51
***Bradford, Gilchrist, Union**				
Bay	Lemuel F. Coxe Jr., Panama City	James D. Nixon, Panama City	1st Tues.	26
Brevard	Theodore J. Kaminski, Melbourne	Paul L. Summers, Melbourne	2nd Tues.	28
Broward	Julius F. Boettner, Fort Lauderdale	George T. F. Rahilly, Fort Lauderdale	4th Tues.	109
Columbia	Robert B. Harkness, Lake City	Thomas H. Bates, Lake City	1st Mon.	12
***Baker, Hamilton**				
Dade	Edward W. Cullipher, Miami	Kenneth S. Whitmer, Miami	1st Tues.	667
DeSoto-Hardee-Highland-Glades	Carl J. Larsen, Avon Park	Samuel A. King, Avon Park	2nd Tues.	26
Duval	Karl B. Hanson, Jacksonville	Jackson L. Allgood Jr., Jacksonville	1st Tues.	271
***Clay**				
Escambia	Wilton E. Tugwell, Pensacola	Paul F. Baranco, Pensacola	2nd Tues.	96
***Santa Rosa**				
Franklin-Gulf	Albert L. Ward, Port St. Joe	Warren T. Weathington, Apalachicola	Last Wed.	9
Hillsborough	C. Frank Chunn, Tampa	Julien C. Pate Jr., Tampa	1st Tues.	179
Indian River	William L. Fitts 3rd, Vero Beach	Vernon L. Fromang, Vero Beach	2nd Tues.	10
Jackson-Calhoun	Jabe A. Breland, Marianna	Francis M. Watson, Marianna	Quarterly	19
Lake	J. Basil Hall, Tavares	James R. Hanson, Tavares	1st Wed.	28
***Sumter**				
Lee-Charlotte-Collier-Hendry	H. Quillian Jones, Fort Myers	James L. Bradley, Fort Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	George H. Massey, Quincy	Odis G. Kendrick Jr., Tallahassee	Quarterly	57
Madison	Wallace E. Winter, Madison	Julian M. DuRant, Madison		4
Manatee	Willett E. Wentzel, Bradenton	Marjorie L. Warner, Bradenton	2nd Tues.	23
Marion	William H. Anderson Jr., Ocala	Bertrand F. Drake, Dunnellon	3rd Tues.	30
***Levy**				
Monroe	Edward Gonzalez, Key West	Herman K. Moore, Key West	2nd Thurs.	12
Nassau	David G. Humphreys, Fernandina	John W. McClane, Fernandina	Last Fri.	11
Orange	Eugene L. Jewett, Orlando	Andrew W. Townes Jr., Orlando	3rd Wed.	182
***Osceola**				
Palm Beach	Thomas E. Daly, West Palm Beach	David A. Newman, Palm Beach	3rd Mon.	131
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Alvin L. Mills, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	217
Polk	Theodore C. Keramidas, Winter Haven	James T. Shelden, Lakeland	2nd Wed.	93
Putnam	Lawrence G. Hebel, Palatka	James A. Long Jr., Palatka	2nd Tues.	10
St. Johns	James J. DeVito, St. Augustine	Reuben J. Plant Jr., St. Augustine	3rd Tues.	19
St. Lucie-Okeechobee-Martin	Laurance D. Van Tilborg, Ft. Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	19
Sarasota	Henry J. Vomacka, Sarasota	Lloyd J. Duest, Sarasota	2nd Tues.	53
Seminole	J. Clifford Boyce, Sanford	Terry Bird, Sanford	2nd Tues.	18
Suwannee	William P. Blackmon, Mayo	Hiram B. Curry, Jasper	1st Sat.	9
Taylor	George H. Warren, Perry	Walter J. Baker, Foley	Last Fri.	4
***Dixie, Lafayette**				
Volusia	Cleland D. Cochrane, Daytona Beach	Robert L. Miller, Daytona Beach	2nd Tues.	86
***Flagler**				
Walton-Okaloosa	Robert von P. Maxon, Fort Walton	Arthur G. Williams Jr., Valparaiso	3rd Thurs.	20
Washington-Holmes	Ralph H. Segrest, Bonifay	Bayllye W. Dalton, Chipley		6
			Total,	2,589

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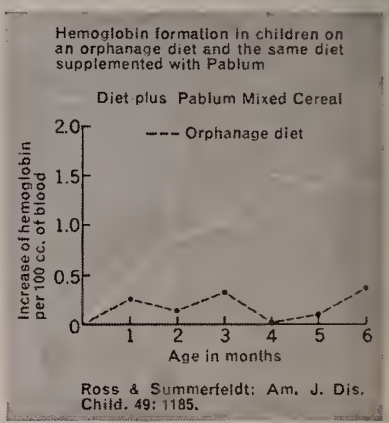
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1. Smith, N. J., and Rosello, S.: J. Clin. Nutrition 1: 275, 1953;
2. Jeans, P. C., in A.M.A. Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 280.

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